

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re: Dr. Foster (2 pages)	n.d.	P5
002. note	re: Dr. Foster (4 pages)	n.d.	P5

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Lyn Hogan
OA/Box Number: 11027

FOLDER TITLE:

Henry Foster Nomination 1995

2010-1083-S

rc448

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

FOR RELEASE UPON DELIVERY
THURSDAY, FEBRUARY 2, 1995

*REMARKS BY

DONNA E. SHALALA

SECRETARY OF HEALTH AND HUMAN SERVICES

NOMINATION OF HENRY W. FOSTER AS SURGEON GENERAL

THE WHITE HOUSE
WASHINGTON, D.C.

*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS.

IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY
BE ADDED OR OMITTED DURING PRESENTATION.

I am truly honored to join President Clinton today in introducing his intended nominee for Surgeon General: Dr. Henry Foster.

Quintessential Clinton-Gore ...

Educated in Arkansas...works in Tennessee.

Dr. Foster has lifted the health status of women and children.

He has been tireless in his efforts to curb infant mortality and prevent teen-pregnancy.

And, he has dedicated his life to ensuring that health care is accessible for all -- not a privilege for the few.

I will be very pleased to have Dr. Foster join us at HHS, where he will report to Dr. Philip Lee, our Assistant Secretary for Health.

As we tackle America's greatest health challenges, we need his energy and his experience, his voice and his vision.

One of those challenges is teenage pregnancy. Every day in America, almost 2,800 teenagers get pregnant. That's a national tragedy -- and the President has insisted on a national campaign to end it.

Henry Foster will help lead that charge. That is why I am so pleased to be here for this announcement.

Now, it is my distinct honor to introduce President Clinton, a man who has shown extraordinary leadership in promoting better health for all Americans. Mr. President

February 2, 1995

Statement

Surgeon General Designate

Henry W. Foster, Jr.

First, I wish to express my appreciation to you, Mr. President for this opportunity to work on behalf of the American people. In many ways, health care in America is a paradox; we hold some of the world's greatest expertise in health interventions. People come from around the globe to be the beneficiaries of this care. Yet, in terms of health care outcomes, we don't do nearly as well as we should as a nation.

As an obstetrician/gynecologist, I can speak directly to the issue of infant mortality, where the U.S. ranks well down the list among western nations. In my view, you can judge the character of a nation by the manner in which it treats its elderly and its children. There is nothing more stifling than a compromised beginning. We must assure healthier starts in the lives of our children.

- More -

Another of my special concerns is the epidemic of adolescent pregnancies. We have the highest teen pregnancy rate in the western world -- twice that of the nearest western nation. Be assured, this is a problem that cuts across all socio-economic strata. There are, however, demonstrated ways that this problem can be mitigated.

It takes commitment and lots of hard work, but it is being done. As you have heard, the "I Have a Future" program is making a difference in Nashville because it has brought together a concerned community that's willing to put in the time and effort to tackle the many roots of the teenage pregnancy problem. As your Surgeon General, this issue will be among my highest priorities.

I will also put tremendous emphasis on other pressing health issues for which prevention can be very effective-- issues such as AIDS and tobacco consumption, especially among our children.

In closing, let me say to you President Clinton, Secretary Shalala, Assistant Secretary for Health, Dr. Phil Lee and all others for whom I will work, I know that together we can demystify and confront the root causes of teen pregnancy, low birth weight, illicit drug use, and the myriad of other health issues with which we will grapple in the coming years.

Lastly, I wish again to say thanks to my wife, daughter and son who have supported me so stoutly in all of my professional and personal endeavors.

Thank you very much.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROLE OF THE SURGEON GENERAL

The Surgeon General holds a major--and historic position within the Public Health Service acting as the "people's doctor," as some have described it. The SG has been the national spokesperson to promote good health activities, alert the nation on things that are harmful or potentially harmful. It was Surgeon General Luther Terry who issued the first Surgeon General's Report on Smoking and Health. More recently, it was Surgeon General C. Everett Koop who wrote the report on AIDS that was mailed to every household in the United States in a major effort to educate the public on the AIDS issue.

The efforts of the Surgeon General to keep this country informed on a variety of health issues is a key responsibility of the office. However, to call the Surgeon General the principal health official/officer of the United States is a misnomer. The Surgeon General serves at the pleasure of the President and under the direction of the Secretary of Health and Human Services, reporting directly to the Assistant Secretary for Health, who also holds the title, Director of the U.S. Public Health Service.

The organizational changes that placed the overall authority for the Public Health Service in the office of the Assistant Secretary, was initiated in the 1960's, in response to the increasingly complex development of the PHS, which has grown to eight separate agencies. Section 201 of Title II of the Public Health Service Act specifically required that the overall leadership and direction of the Public Health Service reside with the Assistant Secretary for Health under the supervision of the Secretary of Health and Human Services.

The Surgeon General's current duties and responsibilities include the direction of the active Commissioned Corps, the component of the Public Health Service that provides medical and allied health professionals for a variety of public health duties throughout the U.S. and overseas.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

On July 16, 1898, Congress passed the act for the Relief of Sick and Disabled Seamen. This act called for the federal government to construct marine hospitals and provide medical care, to and for, merchant seamen. By the end of the Civil War, it was felt that the Marine Hospital Fund was in need of major reform. The reform was led by John Maynard Woodworth who was appointed the first Surgeon General of the Marine Hospital Fund in 1871. The name was then changed to Marine Hospital Service, and the scope of duties assigned to the agency quickly expanded to keep pace with the new nation. In 1912, its name was formally changed to that of Public Health Service to reflect its expanding public health role. The 1944 PHS Act created the modern Public Health Service, expanded PHS authority to award grants for research, construction, and support of state and local health programs.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

February 2, 1995

HENRY W. FOSTER, JR., M.D. - Biography

Henry W. Foster Jr., 61 years old, is a practicing gynecologist and medical educator who is widely recognized as one of the nation's leading authorities on reducing infant mortality and preventing teen pregnancy and drug abuse.

Currently on a one-year sabbatical from Meharry Medical College, where he has served as dean of the school of medicine and acting president, Dr. Foster has been scholar-in-residence at the Association of Academic Health Centers in Washington, D.C., since July, 1994.

The position as scholar-in-residence is the latest in a string of awards and honors to Dr. Foster that include induction into the Institute of Medicine of the National Academy of Sciences; the Appreciation Award for Research and Teaching in Sickle Cell Anemia from Tuskegee University; and the Faculty Award for Excellence in Science and Technology from the White House Initiative on Historically Black Colleges and Universities.

The "I Have a Future Program," developed and directed by Dr. Foster at Meharry, was recognized as one of this nation's "Thousand Points of Light" in 1991 by President George Bush. The program stresses abstinence and steers at-risk teens toward positive life choices through community-based partnerships and interventions.

-MORE-

A skilled communicator, Dr. Foster has lectured extensively at medical conferences and seminars around the world, and colleagues expect him to put the Surgeon General's "bully pulpit" to excellent use in promoting health and preventing disease.

Dr. Foster, a proven consensus builder, has served on numerous boards, committees and councils, most of them concerned with improving perinatal outcomes. They include the March of Dimes Birth Defects Foundation and the American College of Obstetricians and Gynecologists.

He has also served as an examiner for the American Board of Obstetrics and Gynecology and has been a member of the editorial board of Academia, formerly known as the Journal of Medical Education of the American Association of Medical Colleges.

Dr. Foster earned a bachelor of science degree from Morehouse College in 1954 and was awarded his doctor of medicine degree by the University of Arkansas in 1958.

He conducted an internship at the Detroit Receiving Hospital, served two years as a medical officer in the U.S. Air Force, and conducted one year of residency training in general surgery at Malden Hospital in Malden, MA. He completed a three-year residency in obstetrics and gynecology at Meharry Medical College in Nashville, TN.

Dr. Foster is married to the former St. Clair Anderson, a retired critical-care nurse. They have two children: Myrna, a middle school science teacher in McLean, Va.; and Wendell, research director of a Walt Disney Co. television unit in Burbank, Ca.

#####

American Medical Association

Physicians dedicated to the health of America



James S. Todd, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

February 2, 1995

The Honorable William J. Clinton
President of the United States
The White House
Washington, D.C. 20500

Dear Mr. President:

The American Medical Association enthusiastically supports the nomination of Henry W. Foster, Jr., MD for the position of Surgeon General of the U.S. Public Health Service.

Dr. Foster is a leading expert in the field of reproductive health. As Chief of the Department of Obstetrics and Gynecology at the John A. Andrew Memorial Hospital of Tuskegee University, Dr. Foster developed a program which is a nationally recognized model for regionalized perinatal health care systems. During his tenure at Meharry Medical College, Dr. Foster founded the innovative "I Have A Future" program to address teen pregnancy which brought to focus one of the nation's most pressing public health issues. The "I Have A Future" program provides strategies for at-risk youth to develop positive decision-making in the areas of personal health and responsibility, while enhancing their self-image. With so many of our nation's youth in crisis, we need creative programs like this one to dramatically reduce the alarming rate of teen pregnancy and we applaud Dr. Foster's commitment to this issue. Adolescent health has long been a public health priority for the AMA and we look forward to working with Dr. Foster on this and other critical public health issues.

Dr. Foster is a dedicated teacher, a dependable leader, and a concerned advocate for improving access to quality health care for women and underserved populations. Dr. Foster has been a longstanding member of the AMA and he brings the requisite experience, knowledge, and commitment to provide effective leadership as the Surgeon General. We firmly believe that Dr. Foster will serve in the position of Surgeon General with distinction and make many positive contributions to the nation's public health.

Sincerely,

A handwritten signature in dark ink that reads "James S. Todd, MD". The signature is written in a cursive, flowing style.

James S. Todd, MD

MOREHOUSE SCHOOL OF MEDICINE

Office of the President

MSM PRESIDENT ENDORSES SURGEON GENERAL NOMINEE

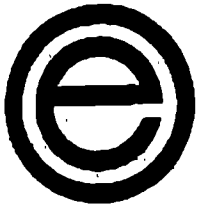
Louis W. Sullivan, M.D., President of Morehouse School of Medicine today released the following statement supporting the appointment of Dr. Henry Foster, Jr., as Surgeon General:

"Dr. Foster is a highly qualified physician and administrator who would be an outstanding Surgeon General. He has had a distinguished academic career and has directed numerous successful community outreach ventures, including Meharry's teen initiative, "I Have A Future Program," focusing on sexual responsibility, self-esteem and job skills.

Dr. Foster is a nationally-known, well-respected physician and a great human being who brings a broad perspective and experience to a variety of health and social issues - knowledge, skills and experience that are essential for America's Surgeon General. I am absolutely confident that he would serve with distinction.

I have known him personally since we were classmates at Morehouse College. I treasure him as a friend and respect him as a colleague."

Louis W. Sullivan, M.D.
President
Morehouse School of Medicine
January 31, 1995



National Association For Equal Opportunity In Higher Education
NAFEO • Black Higher Education Center • Lovejoy Building • 400 12th Street, N.E.
Washington, D.C. 20002 • Telephone (202) 543-9111 • Fax No. (202) 543-9113

Board of Directors

Chairman
Dr. Earl S. Richardson
President, Morgan State
University, Maryland
Chairman-Elect
Dr. Talbert O. Shaw
President, Shaw University
North Carolina

Vice Chairperson
Dr. Henry Givens, Jr.
President, Harris-Stowe
State College, Missouri

Vice Chairperson
Dr. William T. Keaton
President, Arkansas Baptist
College, Arkansas

Vice Chairperson
Dr. Katherine Mitchell
President, Shorter College
Arkansas

Secretary
Dr. Ernest L. Holloway
President, Langston
University, Oklahoma

Treasurer
Dr. Wesley C. McClure
President, Lane College
Tennessee

Past Chairman
Dr. Cordell Wynn
President, Stillman College
Alabama

Dr. Lamora J. Carter
President, Wiley College
Texas

Dr. Douglas Covington
President, Cheyney
University of Pennsylvania
Pennsylvania

Dr. Edward B. Fort
Chancellor, North Carolina
A&T State University
North Carolina

Dr. Robert B. Gex
Chancellor, Southern
University-New Orleans
Louisiana

Dr. David B. Henson
President, Alabama A&M
University, Alabama

Dr. Burnett Joiner
President, LeMoyne-Owen
College, Tennessee

Dr. Thomas M. Law
President, Saint Paul's
College, Virginia

Dr. Lee E. Monroe, Jr.
President, Paul Quinn
College, Texas

Dr. Oscar L. Prater
President, Fort Valley
State College, Georgia

Dr. Frezell R. Robinson
President, Saint Augustine's
College, North Carolina

Dr. Albert J. H. Sloan, II
President, Miles College
Alabama

Dr. Mary L. Smith
President, Kentucky
State University, Kentucky

Dr. Samuel L. Myers
President, NAFEO
Washington, DC

Mrs. Wilma J. Roscoe
Vice President, NAFEO
Washington, DC

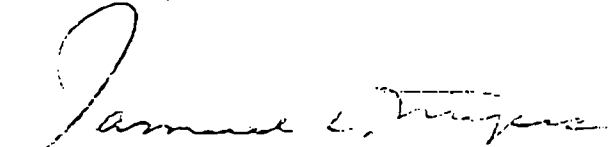
TO WHOM IT MAY CONCERN

On behalf of the National Association for Equal Opportunity in Higher Education (NAFEO), the membership association of 117 historically and predominantly Black colleges and universities (HBCUs), we are pleased to know that Dr. Henry W. Foster, Jr. has been recommended to become the Surgeon General of the United States of America.

I have known Dr. Foster for many years and have long been impressed by his commitment to the health and well-being of all Americans. He has served in a variety of administrative and professional capacities in the Higher Education community including that of Acting President of Meharry Medical College. In addition, his involvement with several organizations and foundations attests to his being able to keep abreast of issues in the medical areas. These accomplishments should serve him well in his new role as Surgeon General.

On behalf of NAFEO, we wholeheartedly endorse and support the appointment of Dr. Henry W. Foster, Jr. as Surgeon General of the United States.

Cordially,


Samuel L. Myers
President

VANDERBILT UNIVERSITY

NASHVILLE, TENNESSEE 37232-2104

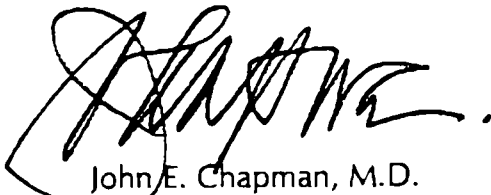
TELEPHONE (615) 322-5000



School of Medicine • Office of the Dean • Direct phone 322-2164 • Fax (615) 343-7286

STATEMENT OF SUPPORT FOR DR. HENRY FOSTER

I have known and worked with Dr. Henry (Hank) Foster for many years. He is a highly qualified and experienced clinician, clinical scientist, educator, medical administrator, and practitioner of problem solving efforts. He is a good friend of good work. He is goal oriented and his goal is a better, healthier life for all Americans. He is a fine choice for Surgeon General.



John E. Chapman, M.D.
Dean of Medicine

American College of
Preventive Medicine

PROVIDING
LEADERSHIP IN
DISEASE PREVENTION
AND HEALTH
PROMOTION

February 2, 1995

William J. Clinton
President of the United States
The White House
Washington, DC 20500

1015 16TH STREET NW
SUITE 403
WASHINGTON, DC 20006
(202) 789-0003
FAX: (202) 289-8274

OFFICERS

ROY L. DEHART, MD
President
HUGH H. TILSON, MD
President-Elect
DOROTHY S. LANE, MD
Secretary-Treasurer

PAST PRESIDENTS

SUZANNE DANDOL, MD
F. DOUGLAS SCUTCHFIELD, MD

EXECUTIVE DIRECTOR
HAZEL K. KEIMOWITZ, MA

REGENTS

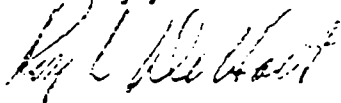
RUSSELL B. RAYMAN, MD
Aerospace Medicine
MICHAEL PARKINSON, MD
General Preventive Medicine
WILLIAM W. GREAVES, MD
Occupational Medicine
CHARLES KONIGSBERG, MD
Public Health
DAVID BUTLER-JONES, MD
Region 1
NANCY SHEEHAN, MD
Region 2
ROBERT CARR, MD
Region 3
TERENCE COLLINS, MD
Region 4
RAY M. NICOLA, MD
Region 5
RICHARD M. BIEKY, MD
Region 6
MARK B. JOHNSON, MD
Region 7
ELLEN S. B. ALKON, MD
Region 8

Dear President Clinton:

The American College of Preventive Medicine is pleased to support the nomination of Henry Foster, MD, for the position of Surgeon General of the United States. Dr. Foster will bring to the position a record of leadership and an understanding of the medical training and health care delivery needs of this nation.

The American College of Preventive Medicine, the national professional society for physicians committed to disease prevention and health promotion, looks forward to working with Dr. Foster on common goals to improve the health of the public.

Sincerely yours,



Roy L. DeHart, MD
President

The
American
College of
Obstetricians and
Gynecologists



Office of President

William C. Andrews, MD, FACOG
880 Kempsville Road, Suite 2200
Norfolk, Virginia 23502
Telephone (804) 466-6350
Fax (804) 461-4816

February 2, 1995

The President of the United States
The White House
700 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. President:

I would like to wholeheartedly endorse, and commend you for, your nomination of Dr. Henry Foster to be Surgeon General of the United States.

I have known Dr. Foster for many years. He is a very intelligent, conscientious, and able physician. His calm well-balanced approach to problem solving will serve him and the people of the United States well in carrying out the duties of the office of Surgeon General.

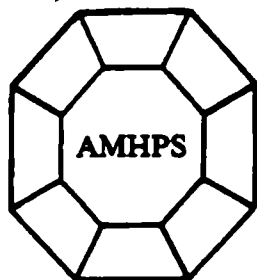
He is highly qualified, and is an excellent choice for the position.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "William C. Andrews".

William C. Andrews, M.D., President
American College of Obstetricians and
Gynecologists

WCA/js



THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

711 Second Street, N.E.

Suite 200

Washington, D.C. 20002

(202) 544-7499

Fax (202) 546-7105

OFFICERS

Henry Lewis III, R.Ph., Pharm.D.
President

David Satcher, M.D., Ph.D.
Immediate Past President

Reed V. Tuckson, M.D.
Vice President

Fred Fielder, D.D.S., M.S.
Secretary/Treasurer

MEMBERS

The Charles R. Drew University of
Medicine and Science
1621 East 120th Street
Los Angeles, California 90059
Reed V. Tuckson, M.D.
President

Meharry Medical College
1005 D.B. Todd Boulevard
Nashville, Tennessee 37208
John E. Maupin Jr., D.D.S., M.B.A.
President
Harold Jordan, M.D.
Acting Dean, School of Medicine
Fred C. Fielder, D.D.S., M.S.
Dean, School of Dentistry

Morhouse School of Medicine
720 Westview Drive, S.W.
Atlanta, Georgia 30310
Louis W. Sullivan, M.D.
President

Florida A&M University
College of Pharmacy
Tallahassee, Florida 32307
Henry Lewis III, R. Ph., Pharm.D.
Dean

Texas Southern University
College of Pharmacy and
Health Sciences
3100 Cleburne Street
Houston, Texas 77004
Mary-Ann Galley, Pharm. D.
Interim Dean

Xavier University of Louisiana
College of Pharmacy
7325 Palmetto Street
New Orleans, Louisiana 70125
Marcellus Grace, Ph.D.
Dean

Tuskegee University School
of Veterinary Medicine
Tuskegee, Alabama 36088
James A. Ferguson, D.V.M., M.P.H., Ph.D.
Dean

Howard University
Colleges of Medicine, Dentistry and Pharmacy
Washington, D.C. 20059
Charles H. Epps Jr., M.D.
Vice President for Health Affairs

Washington Representative
Health and Medicine Counsel
of Washington
Dale P. Dirks

February 2, 1995

The Association of Minority Health Professions Schools (AMHPS) today expressed its support for the nomination of Henry Foster, MD as the Surgeon General of the United States.

AMHPS President, Dr. Henry Lewis stated, "Dr. Foster is a national leader in medicine and research. His efforts to develop programs for the education and academic enrichment of young people, particularly minorities, have been commendable. Dr. Foster's "I Have a Future" program at Nashville's Meharry Medical College is truly a national model."

Dr. Foster is a former acting president of Meharry Medical College. Meharry is an institutional member of AMHPS, which represents the nation's Historically Black medical, dental, pharmacy and veterinary schools.

**For more information
contact: Dale Dirks
(202) 544-7499**



University of Pittsburgh

Graduate School of Public Health

Office of the Dean
111 Parran Hall
130 Desoto Street
Pittsburgh, Pennsylvania 15261
Phone: 412-624-3001
FAX: 412-624-3309

February 2, 1995

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. President:

We, the faculty, staff and students of the Graduate School of Public Health would like to enthusiastically endorse the appointment of Henry Foster, M.D. for the position of Surgeon General.

He brings a broad experience in prevention and public health as well as practice of clinical medicine.

We believe he is an excellent choice.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald R. Mattison", followed by a horizontal line.

Donald R. Mattison, M.D.
Dean

DRM/mjs



National Medical Association

1012 Tenth Street, Northwest • Washington, D.C. 20001
(202) 347-1895 • FAX: (202) 842-3293

TRACY M. WALTON, JR., M.D.
PRESIDENT

February 2, 1995

The President
The White House
Washington, D.C. 20500

Dear Mr President:

The National Medical Association (NMA) strongly supports the nomination of Henry Foster, M.D. as United States Surgeon General. As an active NMA member, Dr. Foster's service has been exemplary and his work has served as a national model that is being replicated in various segments of health care.

The NMA believes that Dr. Foster's presence as U.S. Surgeon General will greatly enhance the Administration's ability and capacity to protect the health and welfare of our nation and applauds your excellent selection.

Sincerely,

Tracy M. Walton, Jr., M.D.
President

Foster a wise choice

THE chain of talent in the leadership of Meharry Medical College in recent years continues to gain national attention.

Speculation concerning the imminent appointment of Dr. Henry Foster as acting president of Meharry is the latest in a chain of talent in the school's next surgeon general is another emphatic statement about the abilities of Meharry's hierarchy.

Dr. David Satcher, former president of the school who first conceived the merger of Metro's General Hospital with Meharry, was selected to head the national Centers for Disease Control in Atlanta. Now, Foster's resume may land him in one of the most important positions in the health-care system nationwide.

If he is indeed chosen, Foster would replace Joycelyn Elders, whose term was marked more by her controversial remarks than actual accomplishment.

Foster, who has been on sabbatical from Meharry since June to serve a fellowship with the Association of Academic Health Centers, would be an inspired choice.

Foster is particularly attuned to the problems of teen pregnancy, one of the principal issues facing U.S. health-care

Excellent physician and effective communicator

An obstetrician/gynecologist, Foster was dean of the Meharry school of Medicine and began a teen pregnancy prevention program. That project, named "Have a Future," focused on positive choices for at-risk teens. The country could use Foster's expertise in the bully pulpit of the surgeon general's post.

But beyond those qualifications, Nashvillians know that Foster has attributes beyond just his knowledge of medicine. He is an effective communicator who could be a strong voice in an office that definitely needs one. It's a safe bet he would not stir the kind of controversy that marred Elders' service.

Americans have shown that they care deeply about the state of health care in this nation. The country needs the type of leadership Foster could provide. The White House couldn't go wrong with Foster's selection. What Meharry has benefited from in the past could once again be a boost to the rest of the country. ■

The Tennessean 2/1/95

Editorial page

Colleagues, others praise Foster's work

By TAMMIE SMITH

Staff Writer

Dr. Henry Foster Jr.'s experience as a practicing physician and his political savvy make him an excellent choice for surgeon general, colleagues and others familiar with his work say.

"Frank has common sense," said Dr. Nat Winston, who worked with Foster on the Meharry-Rubland-Metro General hospitals merger.

"He's not going to make any stu-

pid mistakes."

Foster, according to White House reports, is the leading candidate to replace Dr. Joycelyn Elders. Elders' controversial statements and her subsequent firing in December have brought the post heightened political sensitivity.

Foster, friends say, will get the job done without ruffling too many feathers. The surgeon general is the nation's chief medical officer, issuing policy statements on public health issues.

"He will speak his mind but with dignity, respect and a great deal of diplomacy," said attorney Aubrey Harwell Jr., a member of the Meharry board of trustees.

"He will represent us well," said state Sen. Thelma Harper. "He is very well-respected among his colleagues, locally and nationally."

Others welcomed Foster's medical expertise in reproductive

health.

"This is great," said Dr. Fredia Wadley, Tennessee's new health commissioner, when notified of Foster's possible appointment.

"He has always been an advocate for mothers and babies and public health."

Inez Crutchfield, a member of the board of trustees at Meharry, agreed.

"He is a good researcher in his field."

"He is my personal physician. I think he has proved himself as a person who can do the job."

Clinical psychologist Lorraine Williams-Greene is director of the "I Have A Future Program" at Meharry that Foster founded. She said the program, which seeks to reduce teenage pregnancy and drug use and keep kids in school, has had a measurable impact.

"We do know our kids have more life options," she said. ■

Mike Tennessee 11/21/95

Meharry's Foster may get key post

Believed first in line
for surgeon general

*Tennessean News Services
and Staff Reports*

Dr. Henry W. Foster Jr., former acting president of Meharry Medical College, is expected to be named surgeon general by President Clinton this week, according to unnamed White House sources.

Foster, 61, would replace Dr. Joycelyn Elders, a controversial appointee who was fired in December after saying children should be taught about masturbation in school.

Foster has been on sabbatical from Meharry since June, when he began a yearlong fellowship with the Association of Academic Health Centers in Washington, D.C. He was not available for comment last night.

News of his possible selection to the high-profile post was being lauded by people familiar with his work.

"If it turns out to be true, I, like a lot of people, will be delighted," said Dr. David Satcher, director of the Centers for Disease Control and Prevention and Foster's former boss at Meharry.

"He has a lot of experience in working with young people, and he is one of the world's experts in reproductive health."

Foster, an obstetrician/gynecologist, was dean of the school of medicine at Meharry before taking over as acting president when Satcher departed to direct the CDC.



FOSTER

REACTION

► Excellent pick, colleagues say, on 2A.

At Meharry, Foster started a teen pregnancy prevention program called "I Have A Future" that has been nationally recognized for its efforts to steer at-risk teen-agers to positive life choices.

More recently, Foster guided Meharry during the final stages of a controversial plan to merge Meharry's teaching facility, Hubbard Hospital, with Metro General Hospital, the city's public hospital.

"In the middle of that controversy was Hank Foster, who maintained his dignity and composure," said Dr. Nat Winston, who served on the Metro Board of Hospitals, which approved the merger.

Foster is a 1958 graduate of the University of Arkansas School of Medicine and a 1954 graduate of Morehouse College. ■

TERNESSEAN 1-31-95

Colleagues laud likely surgeon general pick

By Bill Snyder
Banner Senior Medical Writer

Colleagues of longtime Meharry Medical College official Dr. Henry W. Foster Jr. say he would make an "outstanding" U.S. surgeon general.

"He is one of the most outstanding physicians and scientists in the country and the world," says former Meharry president Dr. David Satcher, director of the U.S. Centers for Disease Control and Prevention in Atlanta.

The Associated Press on Monday reported that President Clinton was expected to name Foster as surgeon general later this week, as part of a national campaign to reduce teen-age pregnancy.

Quoting unnamed White House sources, the AP said that Foster's candidacy was going through final review stages, although last-minute "snags" were possible.

Foster, the former dean of medicine and former acting president of historically black Meharry, would succeed Joycelyn Elders, the outspoken Arkansas pediatrician who was fired in December after suggesting that schoolchildren could be taught to masturbate as a way to prevent the spread of the AIDS virus.

Foster, a 61-year-old specialist in obstetrics and gynecology who currently is a "senior scholar" at the Association of Academic Health Centers in Washington D.C., could not be reached for comment.

But sources told the Nashville Banner he currently is the only candidate being considered for the surgeon general's post.

"I hear it looks very good for him," says U.S. Rep. Bob Clement D-Tenn.

"He has a lot of character and he's a real professional," Clement says. "As surgeon general, I think he'd be outstanding."

In his State of the Union address last week, Clinton called teen-age pregnancy "our most serious social problem," and urged parents and community leaders to join a national campaign "to make a difference."

Presidential aides told the Associated Press the new surgeon general will head the project.

Foster founded and was director of Meharry's "I Have A Future" program, which encourages teens to delay pregnancy by building their self-esteem and job skills, emphasizing education, and teaching sexual responsibility and self-control.

Please see FOSTER, page B-4

B-4 Nashville Banner, Tuesday, January 31, 1995

Foster

Continued from page B-1

He also led a national teen-age pregnancy prevention program for the Robert Wood Johnson Foundation, Satcher says.

Foster is nationally recognized for his contributions to health care and health education, colleagues say.

"He knows the issues well," says Dr. Walter Strong, executive vice president of Meharry.

"He has spent all of his professional life dealing with preventive care, prenatal care, and the lives and concerns of children and mothers," adds Dr. Frank Royal, chairman of the Meharry Board of Trustees.

Foster earned his medical degree from the University of Arkansas in 1938.

In 1972, he was named chairman of obstetrics and gynecology at Meharry, a post he held until 1990, when he became dean of Meharry's Medical School.

In 1987, Foster founded the "I Have A Future" program in two of Nashville's public housing developments, with start-up money from the Carnegie Foundation.

The program currently serves about 150 young people each week in a variety of activities, from pre-employment to family life education, program director Lorraine Williams Greene says.

It seems to be working.

A study conducted between

1988 and 1991 found only one of the program's participants became pregnant, compared to 59 teen-age pregnancies in two other Nashville public housing developments that were not offered "I Have A Future," she says.

In addition, 16 of the 24 program participants who graduated from high school last year went on to college, Greene says.

Foster became acting president of Meharry in early 1994, after Satcher left for the CDC.

When Dr. John E. Maupin Jr. became Meharry's ninth president in July, Foster headed for Washington, for a one-year sabbatical to study health care reform.

He has been returning to Nashville once a month to see his gynecology patients, says his wife of 35 years, St. Clair, a retired nurse.

The couple has two children: Wendell, 32, research director for Walt Disney Productions in Burbank, Calif., and Myrna, 31, a teacher in Fairfax, Va.

Satcher says Foster is ideally suited to be surgeon general, especially in "difficult times like this" in which the nation's youth are beset by a wide array of health challenges, from AIDS to homicide.

"He's a good communicator. That's going to be critical," Satcher says, because "there are a lot of opportunities for health promotion and disease prevention that we're missing."

"If there's anybody who can gain the confidence of people in Congress and in the country because of his own integrity and commitment — he exudes that."

AMERICAN NURSES ASSOCIATION

TO: Debbie Fine, Office of Public Liaison
The White House

FROM: Kim Smith, Communications Specialist
American Nurses Association (ANA)

DATE: March 22, 1995

RE: Nomination of Dr. Henry Foster

Cheryl Peterson, Associate Director, ANA Governmental Affairs, recommended I fax this information to you. Please forward to the appropriate person at The White House.

Attached is a copy of the letter sent by ANA President Virginia Trotter Betts, JD, MSN, RN to President Clinton on February 15, 1995, regarding ANA's support of Dr. Henry Foster for the position of Surgeon General of the United States. I have also attached a related article written in the San Jose Mercury News on February 12, 1995.

Thank you.

g:\kim\whitehouse.ltr
03/22/95

4 pages
202-456-2983 (fax)



600 MARYLAND AVENUE SW
SUITE 100 WEST
WASHINGTON, DC 20024-2571
202 651-7000 • FAX: 202 651-7001

VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GERI MARULLO, MS, RN
EXECUTIVE DIRECTOR

February 15, 1995

The President
The White House
Washington D.C. 20500

Dear Mr. President:

I am writing you to express the American Nurses Association strong support of Dr. Henry Foster for the position of Surgeon General of the United States. Dr. Foster has had an extraordinarily distinguished health career focusing on several of nursing's priorities: minority health issues, women's health, and preventive initiatives that facilitate healthy lifestyles and goals.

As Dean of the School of Medicine and President of Meharry Medical College, Dr. Foster has promoted both minority health providers and minority health issues and furthered services for the most vulnerable populations in society.

As a physician, Dr. Foster has specialized in women's health issues, focusing on preventive health for women and children, reducing infant mortality and teenage pregnancy, and fighting drug abuse in pregnant women.

Dr. Foster's much heralded program, "I Have A Future" has served a model for teenagers to become productive citizens in this country by providing education, job skills, responsibility and abstinence for teenagers in Tennessee.

Dr. Foster embodies the ideals that should serve as a foundation for good health in the United States. As an advocate for access to preventive health services, including contraception and maternal and child health, Dr. Foster would be asset as a national spokesperson on the public health issues impacting our lives. ANA enthusiastically supports the nomination of Dr. Henry Foster to be Surgeon General of the United States.

Sincerely yours,

Virginia Trotter Betts
Virginia Trotter Betts
President

G:\pooled\cmd\corr\foster

B

SUNDAY

FEBRUARY 12, 1995 A

San Jose Mercury News**JIM TROTTER**

D.C. serving up bad medicine to Clinton nominee

MY COUSIN Virginia Trotter-Betts is president of the American Nurses Association, and in that capacity is fully involved with national health policy. She is an acquaintance of Dr. Henry Foster Jr., President Clinton's embattled nominee for surgeon general.

Both my cousin and Dr. Foster live in Nashville, where Foster's reputation is pre-eminent, and they have worked together on various health issues. "A terrific person," she said of Foster, "a real pleasant, smart guy."

Foster's nomination has come under withering fire from anti-abortion forces and may be history at this point. Which is too bad, I think, particularly after talking to those who know him. It is one thing to say the right thing, another to actually throw one's self wholeheartedly into the effort. Foster's life is a history of achievement.

Part of this probably has to do with the traditions of Meharry Medical College, where Foster is a faculty member and a former dean and acting president. Meharry opened its doors in Tennessee and began teaching African-Americans the medical sciences only 13 years after the Emancipation Proclamation. It is a proud place, and there is a real lack of

'H E'S A person of the highest ethical character," Meharry President John E. Maupin Jr. said of Foster, "an outstanding clinician and educator."

Said Virginia. "(Foster's) 'I Have a Future' program, started in public housing projects here, has been successful in encouraging kids to delay sex and pregnancy as the best way of seeing themselves through school."

Foster also founded the ASAP program at Meharry, which remains dedicated to saving the lives of infants born to mothers abusing drugs or alcohol.

"The surgeon general is the nation's chief public health officer, and the name of the game is prevention," my cousin said. "This guy has spent a career trying to prevent what everyone in America agrees are major social problems — dropping out, adolescent pregnancy, drug abuse — all the social ills that prevent one from becoming a responsible citizen."

It isn't for nothing that Foster was named one of President Bush's "Thousand Points of Light," but his star isn't exactly shining through the clouds now. Although he has delivered 10,000 babies, he is being opposed as an abortionist.

"He practices in a major medical center," my cousin said. "It would be unethical for him not to have participated in the legal procedures of his specialty (obstetrics-gynecology). In my opinion, it is a specious argument."

'B UT YOU also have to wonder about the thinking in the White House. If abortion is going to be the flash-point issue, what kind of thinking goes into nominating an OB-GYN?"

Foster has said that he "abhors" abortion, but believes that it should be legal, which coincides with the opinion held by a wide spectrum of people. But I don't think his views are the issue here. Foster's works and public record are exemplary in every regard. He should be celebrated. Instead, he is being pilloried.

"His life and entire career has been about saving lives and improving the quality of life," Martha Robinson, a Meharry staff member told me Friday night. "To have his career and professional record distorted in this manner is an atrocity."

Welcome to Washington, Doc. But hold off on unpacking.

Write Jim Trotter at the Mercury News, 750 Ridder Park Drive, San Jose, Calif. 95190; phone (408)

AM
DAEW

ORANIZATION	CONTACT	PHONE	FAX
Am. Academy of Pediatrics	Jackie Noyes	202/336-8600	202/393-6137
Am College of Obstetrics and Gynecology	Kathy Bryant	202/638-2511	488-3985
Advocacy for Youth	Michelle Booth Cole	202/347-5700	202/347-2263
Africare	C. Payne Lucas		
Alpha Kappa Alpha	Sharon Worthy		
Alpha Phi Alpha	Darryl Matthews		
AME Church	Bishop Thomas		
Am. College of Physicians	Howard Shapiro	202/393-1650	
Am. for Democratic Action	Amy Isaacs	202/785-5980	202/785-5969
Am. College of Preventive Medicine	Donna Grossman	202/789-0003	202/289-8274
American Medical Assn.	Rich Deem	202/789-7413	202/789-7401
Am. Medical Women's Assn.	Eileen McGrath	703/838-0500	
Am. Psychiatric Assn.	Deborah Zarin	202/682-6142	
Am. Psychological Assn.	Ray Fowler, CEO Marisa Reddy	202/336-5500	202/336-6063
Assn. of Academic Health Centers	Roger Buldger	202/265-9600	202/265-7514

Assn. of American Medical Colleges	Dick Knapp	202/838-0400	202/828-1125
Assn. of Minority Health Professions Schools	Dale Dirks	202/544-7499	202/546-7105
Assn. of Schools of Public Health	Mike Gemmel	202/842-4668	202/289-8274
Assn. of Reproductive Medicine	Robert Visscher, Ex. Dir.	202/863-4985	202/484-4039
Black Health Assn.	Derrick Humphries		
Black State Legislatures	Chuck Bremer		
Black Women's Network	Ruth Sykes		
B'nai B'rith Women	Jana Goldman, Dir. Comm.	202/857-1320	202/857-1380
Center for Black Aged	Sam Simmons		
Center for Reproductive Law and Policy	Janet Benshoof	212/514-5534	212/514-5538
Delta Sigma Theta	Roseline McKinney		
Feminist Majority	Alice Cohan	703/522-2214	703/522-2219
Human Rights Campaign Fund	Daniel Zingale	202/628-4160	202/347-5323
International Assn. of Black Fire Fighters	Romeo Spaulding		

National Abortion Federation	Donna Singletary	202/667-5881	202/667-5890
NARAL - Nat. Abortion and Reproductive Rights Action League	Kate Michelman Ellen Davis	202/973-3000	202/973-3096
NAACP	Ed Hailes		
Nat. Assn. for Equal Opportunities in Higher Education	Sam Myers, Pres.	202/543-9111	202/543-9113
Nat. Black Chamber of Commerce	Harry Alford		
Nat. Black Nurses Assn.	Patricia Tompkins		
Nat. Black Polic Assn.	Ronald Hampton		
Nat. Black Women's Health Project	Cynthia Newbille, Ex. Dir. or Julia Scott, Dir.	202/835-0117	202/833-8790
Nat. Council of Jewish Women	Deena Margoles	202/296-2588	202/331-7792
Nat. Council of Negro Women	Dorothy Height		
Nat. Family Planning and Reproductive health Assn.	Marilyn Keefe	202/628-3535	202/737-2690
Nat. Hispanic medical Assn.	Elena Rios, MD	202/265-4297	202/234-5468
Nat. medical Assn.	Dr. Tracey Walton	202/347-1896	202/842-3293

Nat. Organziation of Women	Mea Arnold Diane Minor	202/331-0066	202/785-8576
Nat. Organization of Women Legal Defense and Education Fund	Kathryn Rodgers	212/925-6635	212/226-1066
Nat. Women's Law Center	Marcia Greenberger Linda Cooper	202/328-5160	202/328-5137
People for the American Way	Leslie Harris Andrea Hill		
Planned Parenthood Federation of Am.	Diane Pollack	202/785-3351	202/293-4349
Progressive Baptist Convention	Rev. Tyrone Pitts		
SIECUS	Dan Daley	212/819-9770	212/819-9776
Tennessee medical Assn.	Russ Miller	615/385-2100	
United House of Prayer	Bishop Samuel Madison		
Voters for Choice	Julie Brown	202/588-5200	202/588-0600
Zero Population Growth	Brian Dixon	202/332-2200	202/332-2302
Zeta Phi Beta Sorority	Vickie Robinson		

Henry W. Foster Jr., MD

■ Henry W. "Hank" Foster, Jr., M.D. is a *practicing physician, a scholar and academic administrator of national stature, and a community leader*. For the past 21 years, Dr. Foster has been responsible for training some of the nation's finest medical practitioners at Meharry Medical College, where he has been a professor, a department chairman, dean of medicine, and acting president. Dr. Foster is *one of the nation's leading experts on, and advocates for, maternal and child health, and has developed and directed teen-pregnancy and drug-abuse prevention programs* that bolster self-esteem and encourage personal responsibility.

■ Dr. Foster is a *skilled communicator who emphasizes consensus-building over confrontation*. As President Clinton's choice for U.S. Surgeon General, he won enthusiastic endorsements from the American Medical Association, the Association of Schools of Public Health, the National Medical Association, the American College of Obstetricians and Gynecologists, among others. He was endorsed by his hometown newspaper, The Nashville Tennessean, even before being officially named. Dr. Foster's supporters cite his distinguished career, commitment to the health of women and children and his impeccable personal credentials.

■ Dr. Foster has *strong bipartisan support*. Former HHS Secretary Dr. Louis Sullivan has lauded his selection to be the next Surgeon General. In 1991, President George Bush named the "I Have A Future Program" that Dr. Foster developed as one of this nation's "Thousand Points of Light" for its pioneering work in reducing teen pregnancy. He served on Tennessee Governor Lamar Alexander's Task Force on Healthy Children and chaired its subcommittee on infant mortality. In 1972, Dr. Foster was one of the youngest doctors ever inducted into the prestigious Institute of Medicine of the National Academy of Science, and he has served on local and national boards of such organizations as the March of Dimes Birth Defects Foundation, the American Cancer Society, the Young Women's Christian Association and the American College of Obstetricians and Gynecologists.

**REACTIONS TO THE NOMINATION OF HENRY W. FOSTER, JR., MD
TO THE POST OF SURGEON GENERAL**

"Dr. Foster is a dedicated teacher, a dependable leader, and a concerned advocate for improving access to quality health care for women and underserved populations...We firmly believe that Dr. Foster will serve in the position of Surgeon General with distinction and make many positive contributions to the nation's public health."

**--James S. Todd, MD
Executive Vice President
American Medical Association**

"Dr. Foster is a highly qualified physician and administrator who would be an outstanding Surgeon General...I am absolutely confident that he would serve with distinction."

**--Louis W. Sullivan
President, Morehouse School of Medicine
Health and Human Services Secretary under President Bush**

"The country could use Foster's expertise in the bully pulpit of the surgeon general's post...He is an effective communicator who could be a strong voice in an office that definitely needs one...The country needs the type of leadership Foster could provide."

**--The Tennessean Editorial Page
2/1/95**

"As an active NMA member, Dr. Foster's service has been exemplary and his work has served as a national model that is being replicated in various segments of health care. The NMA believes that Dr. Foster's presence as U.S. Surgeon General will greatly enhance the Administration's ability and capacity to protect the health and welfare of our nation..."

**--Tracy M. Walton, Jr., MD
President, National Medical Association (NMA)**

"His head is not bumping the clouds. In the job of Surgeon General you have to be able to voice your views and stay in the mainstream at the same time. Otherwise, you'll lose your pulpit. Hank Foster can do that. He's a person in a class with Dr. Koop."

**--Dr. James E. Word
Vice President of Baptist Hospital in Nashville and a Foster colleague**

"He has a lot of character and he's a real professional. As surgeon general, I think he'd be outstanding."

--Rep. Bob Clement, (D-TN)

MARCH 15, 1995

MEMORANDUM FOR WHITE HOUSE STAFF

FROM: MARILYN YAGER

RE: SUPPORTERS FOR THE FOSTER NOMINATION

The attached list of national groups supporting the Foster nomination now exceeds 100.

**Dr. Foster Supporters
As of March 15, 1995**

ADVOCATES FOR YOUTH
AFRICAN METHODIST EPISCOPAL CHURCH
ALPHA KAPPA ALPHA SORORITY
ALPHA PHI ALPHA FRATERNITY
AMERICAN ACADEMY OF DERMATOLOGY
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN CATARACT SOCIETY
AMERICAN FEDERATION OF STATE, COUNTY,
AND MUNICIPAL EMPLOYEES, AFL-CIO
AMERICAN ASSOCIATION OF UNIVERSITY
WOMEN
AMERICAN ASSOCIATION OF DENTAL
SCHOOLS
AMERICAN COLLEGE OF PHYSICIANS
AMERICAN COLLEGE OF OBSTETRICIANS AND
GYNECOLOGISTS
AMERICAN COLLEGE OF PREVENTIVE
MEDICINE
AMERICAN JEWISH CONGRESS
AMERICAN MEDICAL ASSOCIATION
AMERICAN MEDICAL WOMEN'S ASSOCIATION
AMERICAN NURSES ASSOCIATION
AMERICAN PEDIATRIC SOCIETY
AMERICAN PSYCHIATRIC ASSOCIATION
AMERICAN PSYCHOLOGICAL ASSOCIATION
AMERICAN PUBLIC HEALTH ASSOCIATION
AMERICAN SOCIETY FOR REPRODUCTIVE
MEDICINE
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
AMERICANS FOR DEMOCRATIC ACTION
AMERICANS UNITED FOR SEPARATION OF
CHURCH AND STATE
ASSOCIATION OF ACADEMIC HEALTH
CENTERS
ASSOCIATION OF AMERICAN MEDICAL
COLLEGES
ASSOCIATION OF BLACK CARDIOLOGISTS
ASSOCIATION OF MEDICAL SCHOOL
PEDIATRIC CHAIRMAN
ASSOCIATION OF MINORITY HEALTH
PROFESSIONS SCHOOLS
ASSOCIATION OF PROFESSORS OF
OBSTETRICS AND GYNECOLOGY
ASSOCIATION OF SCHOOLS OF PUBLIC
HEALTH
ASSOCIATION OF STATE AND TERRITORIAL
HEALTH OFFICIALS
ASSOCIATION OF TEACHERS OF PREVENTIVE
MEDICINE
BAPTIST MINISTERS ASSOCIATION
B'NAI B'RITH WOMEN
CAMPAIGN FOR WOMEN'S HEALTH
CATHOLICS FOR A FREE CHOICE
CENTER FOR WOMEN POLICY STUDIES
CENTER FOR REPRODUCTIVE LAW & POLICY
CHILDREN'S HEALTH FUND
CLARA BELL DUVALL EDUCATION FUND
COALITION OF BLACK TRADE UNIONS
COALITION OF LABOR UNION WOMEN
COUNCIL OF UNIVERSITY CHAIRS OF
OBSTETRICS AND GYNECOLOGY
COUNCIL ON RESIDENT EDUCATION IN
OBSTETRICS AND GYNECOLOGY
DELTA SIGMA THETA SORORITY
ENDOCRINE SOCIETY
ECUMENICAL MINISTERIAL ASSOCIATION
HUMAN RIGHTS CAMPAIGN FUND
INTERNATIONAL WOMEN'S HEALTH
COALITION
KAPPA ALPHA PSI FRATERNITY
MEDICAL STUDENTS FOR CHOICE
NATIONAL ABORTION AND REPRODUCTIVE
RIGHTS ACTION LEAGUE
NATIONAL ABORTION FEDERATION
NATIONAL ALLIANCE OF BLACK SCHOOL
EDUCATORS
NATIONAL ASIAN WOMEN'S HEALTH
ORGANIZATION
NATIONAL ASSOCIATION FOR THE
ADVANCEMENT OF COLORED PEOPLE
NATIONAL ASSOCIATION FOR EQUAL
OPPORTUNITY IN HIGHER EDUCATION
NATIONAL ASSOCIATION FOR PUBLIC
HEALTH POLICY
NATIONAL ASSOCIATION OF PEOPLE WITH
AIDS
NATIONAL ASSOCIATION OF PUBLIC
HOSPITALS
NATIONAL ASSOCIATION OF SOCIAL
WORKERS
NATIONAL BAPTIST CONVENTION, INC.
NATIONAL BAR ASSOCIATION
NATIONAL BLACK CAUCUS OF STATE
LEGISLATORS
NATIONAL BLACK CHAMBER OF COMMERCE
NATIONAL BLACK CHILD DEVELOPMENT
INSTITUTE
NATIONAL BLACK NURSES' ASSOCIATION
NATIONAL BLACK WOMEN'S HEALTH PROJECT
NATIONAL COUNCIL OF JEWISH WOMEN
NATIONAL COUNCIL OF NEGRO WOMEN
NATIONAL COUNCIL OF SENIOR CITIZENS
NATIONAL EDUCATION ASSOCIATION
NATIONAL FAMILY PLANNING &
REPRODUCTIVE HEALTH ASSOCIATION
NATIONAL HISPANIC MEDICAL ASSOCIATION
NATIONAL MEDICAL ASSOCIATION
NATIONAL ORGANIZATION FOR WOMEN
NATIONAL WOMEN'S LAW CENTER
NOW LEGAL DEFENSE AND EDUCATION FUND
OLDER WOMEN'S LEAGUE
100 BLACK WOMEN INC.
OPERATION PUSH, INC.
PEOPLE FOR THE AMERICAN WAY
PHYSICIANS FOR SOCIAL RESPONSIBILITY
PLANNED PARENTHOOD FEDERATION OF
AMERICA
PHI BETA SIGMA FRATERNITY
PRIMARY CARE DEVELOPMENT CORPORATION
PROGRESSIVE BAPTIST CONVENTION
RELIGIOUS COALITION FOR REPRODUCTIVE
CHOICE
SEXUALITY, INFORMATION AND EDUCATION
COUNCIL OF THE UNITED STATES
SOCIETY FOR ADOLESCENT MEDICINE
SOCIETY FOR PEDIATRIC RESEARCH

SUMMIT '93 HEALTH COALITION
BNUNITED CHURCH OF CHRIST, OFFICE FOR
CEURCH AND SOCIETY
UNITED HOUSE OF PRAYER FOR ALL PEOPLE
UNITED METHODIST CHURCH, GENERAL
COMMISSION ON RELIGION AND RACE
UNITY FELLOWSHIP CHURCH MOVEMENT
VOTERS FOR CHOICE
WIDER OPPORTUNITIES FOR WOMEN
WOMEN'S LLEGAL DEFENSE FUND
ZERO POPULATION GROWTH
ZETA PHI BETA SORORITY

Dr. Foster Nomination Picking Up Steam

February 16, 1995

"Just in the past 48 hours, I've witnessed a turnaround in the kind of support and the strength there is for [the] nomination." (Senate Minority Leader Tom Daschle, 12/15/95)

Dr. Foster shows a ``passion for dealing with some of the tough issues that face America. Maybe some of the people who care about families would do well to reconsider their positions." (Bishop Frederick James, AME Church, 12/15/95)

BROAD SHOW OF SUPPORT FOR DR. FOSTER

Dr. Foster is receiving endorsements from groups representing a broad cross-section of America. Today, the American Medical Women's Association, the National Education Association, the Planned Parenthood Federation of America, the Association of Schools of Public Health and other civic, religious and women's groups will hold a press conference to announce their support of Dr. Foster's nomination. Yesterday at the White House, 30 black religious, educational and medical groups leaders strongly endorsed him and said they would lobby for his confirmation.

GOOD RECEPTION ON THE HILL

Today, Dr. Foster will meet with leading Republican Senators for an open dialogue on his distinguished record and qualifications. Yesterday, he made a round of courtesy calls to Senate Democrats who gave him high marks. Sen. Carol Moseley-Braun (D-IL) said, "The more his reputation is known, the more he speaks, the more people understand that his opponents have extremist views and that his whole career has been about valuing life."

RESPONSIBLE REPUBLICANS GIVING DR. FOSTER A FAIR HEARING

Those Republicans who are interested in having the best qualified Surgeon General are determined to keep an open mind and give Dr. Foster a fair hearing. Nancy Johnson (R-CT), whose husband is a practicing ob/gyn, told a radio talk show this week that "Republican senators have taken advantage of the situation to launch a very narrowly-based, mean-spirited campaign of opposition. There isn't an obstetrician in America that was trained during the time Dr. Foster was trained, that practiced during the years he practiced, that hasn't terminated a pregnancy. There isn't one."

SETTING THE RECORD STRAIGHT

Right-wing extremists will escalate the rhetoric and let the false charges fly. Groups that seek to criminalize a woman's right to choose have tremendous resources at their disposal and will say and do anything to defeat this nomination. We will rebut that misinformation and set Dr. Foster's record straight. Dr. Foster is a highly respected obstetrician/gynecologist and one of the leading medical educators in the country. In his distinguished 38-year career, Dr. Foster has delivered thousands of babies and instructed hundreds of young physicians. His "I Have a Future" program to promote abstinence and fight teen pregnancy is a national model - named one of President Bush's Thousand Points of Light.

ORGANIZATIONS SUPPORTING DR. HENRY FOSTER

Advocates for Youth
African Methodist Episcopal Church
Africare
Alpha Kappa Alpha
American Academy of Pediatrics
American Association of Dental Schools
American College of Obstetricians and
Gynecologists
American College of Physicians
American for Democratic Action
American College of Preventive Medicine
American Medical Association
American Medical Women's Association
American Nurses Association
American Psychiatric Association
American Psychological Association
American Society for Reproductive Choice
Association of Academic Health Centers
Association of American Medical Colleges
Association of Minority Health Professions
Schools
Association of Reproductive Medicine
Association of Schools of Public Health
Association of Teachers of Preventive Medicine
Black Health Association
Black Women's Network
B'nai B'rith Women
Catholics for Free Choice
Center for Black Aged
Center for Reproductive Law and Policy
Clara Bell Duvall Education Fund
Delta Sigma Theta
The Endocrine Society
Feminist Majority
Human Rights Campaign Fund
International Association of Black Fire Fighters
Medical Students for Free Choice
National Abortion Federation

National Abortion and Reproductive Rights
Action League
National Association for the Advancement of
Colored People
National Association for Equal Opportunities in
Higher Education
National Association of Black Cardiologists
National Association of Public Hospitals
National Association of Social Workers
National Black Chamber of Commerce
National Black Nurses Association
National Black Police Association
National Black Women's Health Project
National Caucus of Black State Legislatures
National Council of Jewish Women
National Council of Negro Women
National Council of Senior Citizens
National Education Association
National Family Planning and Reproductive
Health Association
National Hispanic Medical Association
National Medical Association
National Progressive Baptist Convention
National Organization for Women
National Organization for Women Legal Defense
and Education Fund
National Urban League
National Women's Law Center
People for the American Way
Planned Parenthood Federation of America
Sexuality Information and Education Council of
the United States
Voters for Choice
Zero Population Growth
Zeta Phi Beta

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

February 2, 1995

HENRY W. FOSTER, JR., M.D. - Biography

Henry W. Foster Jr., 61 years old, is a practicing gynecologist and medical educator who is widely recognized as one of the nation's leading authorities on reducing infant mortality and preventing teen pregnancy and drug abuse.

Currently on a one-year sabbatical from Meharry Medical College, where he has served as dean of the school of medicine and acting president, Dr. Foster has been scholar-in-residence at the Association of Academic Health Centers in Washington, D.C., since July, 1994.

The position as scholar-in-residence is the latest in a string of awards and honors to Dr. Foster that include induction into the Institute of Medicine of the National Academy of Sciences; the Appreciation Award for Research and Teaching in Sickle Cell Anemia from Tuskegee University; and the Faculty Award for Excellence in Science and Technology from the White House Initiative on Historically Black Colleges and Universities.

The "I Have a Future Program," developed and directed by Dr. Foster at Meharry, was recognized as one of this nation's "Thousand Points of Light" in 1991 by President George Bush. The program stresses abstinence and steers at-risk teens toward positive life choices through community-based partnerships and interventions.

-MORE-

A skilled communicator, Dr. Foster has lectured extensively at medical conferences and seminars around the world, and colleagues expect him to put the Surgeon General's "bully pulpit" to excellent use in promoting health and preventing disease.

Dr. Foster, a proven consensus builder, has served on numerous boards, committees and councils, most of them concerned with improving perinatal outcomes. They include the March of Dimes Birth Defects Foundation and the American College of Obstetricians and Gynecologists.

He has also served as an examiner for the American Board of Obstetrics and Gynecology and has been a member of the editorial board of Academia, formerly known as the Journal of Medical Education of the American Association of Medical Colleges.

Dr. Foster earned a bachelor of science degree from Morehouse College in 1954 and was awarded his doctor of medicine degree by the University of Arkansas in 1958.

He conducted an internship at the Detroit Receiving Hospital, served two years as a medical officer in the U.S. Air Force, and conducted one year of residency training in general surgery at Malden Hospital in Malden, MA. He completed a three-year residency in obstetrics and gynecology at Meharry Medical College in Nashville, TN.

Dr. Foster is married to the former St. Clair Anderson, a retired critical-care nurse. They have two children: Myrna, a middle school science teacher in McLean, Va.; and Wendell, research director of a Walt Disney Co. television unit in Burbank, Ca.

#####

February 2, 1995

Statement

Surgeon General Designate

Henry W. Foster, Jr.

First, I wish to express my appreciation to you, Mr. President for this opportunity to work on behalf of the American people. In many ways, health care in America is a paradox; we hold some of the world's greatest expertise in health interventions. People come from around the globe to be the beneficiaries of this care. Yet, in terms of health care outcomes, we don't do nearly as well as we should as a nation.

As an obstetrician/gynecologist, I can speak directly to the issue of infant mortality, where the U.S. ranks well down the list among western nations. In my view, you can judge the character of a nation by the manner in which it treats its elderly and its children. There is nothing more stifling than a compromised beginning. We must assure healthier starts in the lives of our children.

- More -

Another of my special concerns is the epidemic of adolescent pregnancies. We have the highest teen pregnancy rate in the western world -- twice that of the nearest western nation. Be assured, this is a problem that cuts across all socio-economic strata. There are, however, demonstrated ways that this problem can be mitigated.

It takes commitment and lots of hard work, but it is being done. As you have heard, the "I Have a Future" program is making a difference in Nashville because it has brought together a concerned community that's willing to put in the time and effort to tackle the many roots of the teenage pregnancy problem. As your Surgeon General, this issue will be among my highest priorities.

I will also put tremendous emphasis on other pressing health issues for which prevention can be very effective-- issues such as AIDS and tobacco consumption, especially among our children.

In closing, let me say to you President Clinton, Secretary Shalala, Assistant Secretary for Health, Dr. Phil Lee and all others for whom I will work, I know that together we can demystify and confront the root causes of teen pregnancy, low birth weight, illicit drug use, and the myriad of other health issues with which we will grapple in the coming years.

Lastly, I wish again to say thanks to my wife, daughter and son who have supported me so stoutly in all of my professional and personal endeavors.

Thank you very much.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROLE OF THE SURGEON GENERAL

The Surgeon General holds a major--and historic position within the Public Health Service acting as the "people's doctor," as some have described it. The SG has been the national spokesperson to promote good health activities, alert the nation on things that are harmful or potentially harmful. It was Surgeon General Luther Terry who issued the first Surgeon General's Report on Smoking and Health. More recently, it was Surgeon General C. Everett Koop who wrote the report on AIDS that was mailed to every household in the United States in a major effort to educate the public on the AIDS issue.

The efforts of the Surgeon General to keep this country informed on a variety of health issues is a key responsibility of the office. However, to call the Surgeon General the principal health official/officer of the United States is a misnomer. The Surgeon General serves at the pleasure of the President and under the direction of the Secretary of Health and Human Services, reporting directly to the Assistant Secretary for Health, who also holds the title, Director of the U.S. Public Health Service.

The organizational changes that placed the overall authority for the Public Health Service in the office of the Assistant Secretary, was initiated in the 1960's, in response to the increasingly complex development of the PHS, which has grown to eight separate agencies. Section 201 of Title II of the Public Health Service Act specifically required that the overall leadership and direction of the Public Health Service reside with the Assistant Secretary for Health under the supervision of the Secretary of Health and Human Services.

The Surgeon General's current duties and responsibilities include the direction of the active Commissioned Corps, the component of the Public Health Service that provides medical and allied health professionals for a variety of public health duties throughout the U.S. and overseas.

Dr. Foster At-A-Glance: Henry W. Foster M.D., 61, is an eminent scholar and academic administrator, a practicing physician, and a community leader. In 1972, he was one of the youngest members ever inducted into the Institute of Medicine of the National Academy of Science. In 1991, the "I Have A Future" program he developed was named a "Point of Light" by President Bush for its pioneering work in preventing teen pregnancy and building self-esteem among at-risk youth.

EDITORIAL SUPPORT FOR HENRY W. FOSTER, JR., M.D.

"Instead of fixating on the number of abortions performed by Foster, how about answering the most pertinent question: Is he qualified to be the nation's public health spokesman? Yes, if you judge Foster on his medical credentials and community service.

"A dean and acting president of Meharry Medical College, Foster has been endorsed by the American Medical Association and ACOG. He's won national recognition and awards for his campaign to reduce infant mortality and to curb teen pregnancy and drug abuse. His *I Have a Future* program encourages young people to delay sexual activity, develop job skills and improve self-esteem. As Surgeon General, Foster says he will continue working to reduce out-of-wedlock pregnancy."

-- USA Today, Feb. 7

"Dr. Henry Foster has an excellent background to be the next surgeon general. ... Foster's commitment to reducing teen-age pregnancy and its rippling effects on children is longstanding and deeply felt. ... While practicing in Massachusetts and Alabama as well as Tennessee, Foster was committed to reducing teen-age pregnancy, drug abuse and smoking. His work has generated support from many directions; the Bush Administration referred to him as one of its "thousand points of light."

-- Los Angeles Times, Feb. 7

"Foster appears to be the right person to speak to the nation about public health. He has been nationally recognized for his *I Have a Future* campaign to persuade teen-agers to forgo teen sex ... and develop job skills."

-- Philadelphia Daily News, Feb. 8

"Ultimately, what matters most is the totality of Foster's medical practice and his service to his community. From all accounts, he has been a conscientious physician, a respected educator and the originator of an admired program to reduce teen pregnancies in Nashville. ... A medical professional with Foster's credentials deserves a fair confirmation hearing, not a witch hunt arranged by abortion foes."

-- **Atlanta Journal-Constitution, Feb. 8**

"[T]he Tennessee obstetrician-gynecologist, whom President Clinton picked last week to replace Dr. Joycelyn Elders, made a name for himself by delivering babies -- thousands and thousands of them -- and by preaching abstinence to teenagers in two Nashville housing projects.

"Members of the Senate, where the Foster nomination will survive or die, ought to withhold judgment until after hearings. They should weigh the doctor's total record, too, including the *I Have a Future* program he started in Nashville to urge teenagers to delay sexual relations and childbearing."

-- **Chicago Tribune, Feb. 7**

"[President Clinton] should stand behind what seems like a well-qualified candidate. Foster is no apologist for teen-age sex, as his predecessor, Dr. Joycelyn Elders, was sometimes accused of being. Indeed, he has effectively preached sexual abstinence as by far the wisest and safest choice for teenagers. ... Foster's work to curb teenage pregnancies caused him to be honored as a "Point of Light" by former President George Bush."

-- **Denver Post, Feb. 9**

"Instead of narrowly focusing on a single issue, Foster's detractors ought to consider his many qualifications. Foster is widely known for his *I Have a Future* program to reduce pregnancy among teens in public housing in Nashville. Preventing teen pregnancy, research shows, is critical to help reduce associated problems, including welfare dependency, child abuse and neglect.

"We urge President Clinton to hang tough on Foster's nomination. Whatever one may think about abortion, fact is it's legal. A qualified professional ought not be rejected for public service simply because he provided a legal medical procedure."

-- **Chicago Sun-Times, Feb. 7**

"It's up to the rational members of Congress to seize control of the discussion about Foster's qualifications. So far, he looks like a good fit for the job of fighting the teen pregnancy epidemic."

-- **San Jose, Calif., Mercury News, Feb. 6**

"Foster appears to be well qualified and well suited for the job. His program in Nashville directed at teen-agers is named "I Have a Future." It operates in two housing projects and advocates delaying sex and childbearing as important to the development of successful lives. There have been few pregnancies among the teens in the program, which began in 1987, and many have finished high school and gone on to higher education. With teen-age pregnancy among the nation's most serious problems, Foster's leadership in this troublesome area would be welcome indeed."

-- **Seattle Post-Intelligencer, Feb. 8**

"Foster's record of service strikes at the very heart of what many members of the new Congress, including conservative Republicans, have been advocating. His *I Have a Future* program, aimed at curbing teen pregnancy, have been advocating. His *I Have a Future* program, aimed at curbing teen pregnancy, has targeted at-risk young people, instilling in them a sense of responsibility. The program was hailed by the Bush administration as one of its 1,000 Points of Light."

-- **The Tennessean, Feb. 7**

The American College of Obstetricians and Gynecologists

STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

PRESS CONFERENCE: "MEDICAL COMMUNITY SUPPORT OF HENRY W. FOSTER, M.D.,
NOMINEE FOR SURGEON GENERAL"
NATIONAL PRESS CLUB -- WASHINGTON, D.C.
FEBRUARY 10, 1995 -- 9 A.M.

RALPH W. HALE, M.D., F.A.C.O.G.
ACOG EXECUTIVE DIRECTOR

The American College of Obstetricians and Gynecologists (ACOG), representing over 35,000 physicians specializing in women's health care, is here today to wholeheartedly and unequivocally support the nomination of Dr. Henry W. Foster as Surgeon General. And we are joined by other organizations representing thousands of doctors across this country.

We are here today to applaud Dr. Foster's accomplishments, not to apologize for them.

His career should be celebrated, not defended.

His knowledge should be shared with the nation, not silenced.

Dr. Henry Foster's career achievements are well-known. He has been on the faculty of Nashville's Meharry Medical College since 1973, where he has served as Dean of the School of Medicine and as Acting President, and as Vice President for Health Affairs. He is a Professor and past Chairman in the Department of Obstetrics and Gynecology at Meharry. He is currently on sabbatical as a health policy fellow at the Association of Academic Health Centers in Washington, D.C. He has served as Chief of Ob-Gyn at Larson Air Force Base. He has been President of the Association of Professors of Gynecology and Obstetrics, an examiner for the American Board of Obstetrics and Gynecology, and he is a member of the prestigious Institute of Medicine.

Dr. Foster is a widely-known, popular, and respected member of the College, which represents over 90 percent of all the board-certified ob-gyns in this country. He has served with distinction on numerous College committees, dealing with issues ranging from education in family life to ambulatory care, maternal health, and resident education.

I personally know Hank Foster. Let me tell you what makes him special. He is the kind of compassionate, caring, and committed doctor that we all want as our personal physician, and that America will value as the nation's physician.

-- more --

Dr. Foster has chosen for his life's mission to work with people who need help the most, those who might not otherwise have access to health care. He is exceptionally qualified to take on the health challenges that face our nation -- from infant mortality, to sexually transmissible diseases, drug and alcohol abuse, violence in our cities' streets, and teen-age pregnancy.

Dr. Foster's widely-acclaimed "I Have a Future" program encourages young people to delay sexual activity and to develop job skills and self-esteem. Reducing teen-age pregnancy has been a stated goal of Congress and the President for some time now. It is a major public health issue. Who better to lead the nation's dialogue on this question than someone who has worked on this problem successfully on a day-to-day basis for many years?

Dr. Foster has dedicated his life to caring for women and their babies -- delivering over 10,000 of them -- and to promoting the health of their families.

In spite of Dr. Foster's illustrious record, there are some who would deny him a hearing before the nomination process has even begun. The key word here is "process," that is, a full-fledged discussion of his qualifications before the United States Senate.

A hearing does not mean one editorial, or a thirty-second sound bite. A hearing means a deliberative process before the duly-elected representatives of the American people.

What's right about this process is the choice of Dr. Foster for Surgeon General; what's wrong is how we set our public servants up to fail before they are allowed to speak for themselves.

There are some who would use the abortion issue as a litmus test for judging a doctor's capacity for public service. Those of us here today -- even with our differences in personal views -- do not share that belief. We represent different types of doctors, treating different types of patients, in a variety of settings -- from public health clinics and pediatric offices to emergency rooms. We judge Dr. Foster on the totality of his career.

Within our own specialty of ob-gyn, for example, about 13 percent of our members oppose abortion. Many of them have called me this week, to say that Dr. Foster is a fine man who deserves a fair hearing. One of them, Dr. James Youngblood of Kansas City, whose statement we hand out today, says clearly, "He should be the Surgeon General -- we need him!"

That is the point. We do need Dr. Henry Foster. His gift to this country is his life's work, and he will serve us well.

####

Remarks as prepared for delivery by
Dr. Henry Foster
Nominee for U.S. Surgeon General
at
George Washington University -- School of Public Health
February 10, 1995

Thank you, Alan Weingold for that gracious introduction. It is a pleasure to be here at this prestigious university.

You guys gave me a lot of inspiration.

Nobody expected your men's basketball team to beat the number one team in the country last week, but you did.

So I know you understand what it feels like to have a tough battle ahead of you.

It is fitting that the President announced his intent to nominate me for the position of Surgeon General on February the second, Groundhog Day.

That's the day when, if the groundhog sees its shadow, we know we're in for six more weeks of winter. But if the groundhog doesn't see it, we know that spring is just around the corner.

I feel a little bit like that groundhog.

Because ever since February the second -- when President Clinton and Secretary Shalala publicly called me to service -- the descriptions of myself and my work that I have read in the papers and seen on TV have cast an unrecognizable shadow of the man I really am.

Yes, I see a shadow, but it's not my shadow.

And that means Spring is just around the corner.

In his announcement of my nomination, the President thanked me for taking on the difficult task of public service at a time when public service sometimes has a high price.

I thought I knew what he meant at the time.

But after the past week -- I really know what he meant.

So you might be wondering, why do I want this job?

Let me tell you.

If you've been listening to the news lately, you may have gotten the wrong idea about my professional career.

I have been a doctor for 38 years.

I have run a major health sciences center, comprised of four schools: medicine, dentistry, allied health, and graduate studies.

In 1972, I became one of the youngest people ever inducted into the Institute of Medicine of the National Academy of Sciences.

I am the founder of the award-winning "I Have a Future Program," which was recognized as one of this nation's "Thousand Points of Light" in 1991 by President George Bush.

I am also a husband of 35 years and the father of a daughter and a son.

For the past 38 years, as a teacher, a university leader, and a practicing obstetrician/gynecologist, I have dedicated my entire professional life to bringing healthy lives into this world -- and helping people reach their full potential.

I have personally delivered thousands and thousands of babies.

While chair of the Department of OB-GYN at Meharry Medical College, I taught more than 1500 students. Founded 119 years ago, Meharry is among the nation's finest teaching institutions.

And I have worked tirelessly to improve the health of newborns, unborns, and their mothers.

When you've had the good fortune to participate in the miracle of birth as many times as I have, it is difficult to stand on the sidelines and watch so many people wasting the precious gift of life...

It is difficult to look around America today and see so much needless suffering because of a lack of knowledge about prevention...

...or a lack of access and utilization of quality health care...

...or the lack of those basic values that prevent violence or abuse from taking root.

But all is not lost.

America is moving forward to confront both our health care crisis and the crisis of values that has led to too much irresponsible behavior.

As your Surgeon General -- working with you and all Americans -- I believe that I can turn the small ripples of success that we have produced into great waves of progress.

I believe that I can help empower more people to reclaim the power over their own health ...

... That I can help inspire people in communities all across this nation to put a stop to dangerous and destructive behaviors...

... That I can help draw more attention to the tragic public health problems confronting us -- From the epidemic of violence to the spread of AIDS to the terrible problem of substance abuse.

The biggest tragedy is that these conditions are largely preventable and the deaths they cause are so often unnecessary.

Take violence, for example.

I believe we have the power to eradicate this scourge and prevent its recurrence.

At least 2.2 million Americans are victims of violent injury each year.

In 1992, there were more than 37,000 firearm-related deaths in this country.

Escalating violence in America causes not only unnecessary injury and death;

It is also a major cause of the disintegration and the hopelessness that pervade so many of our communities.

We can dig at the root causes of this epidemic and we can weed it out of existence.

I know we can -- but it's going to take entire communities, working together.

Then there's drug and alcohol abuse.

A growing number of our young people are using illicit drugs and ruining their chances to grow into healthy and productive adulthood.

Recent surveys by the Department of Health and Human Services confirm that for three years in a row, the use of marijuana and other drugs by 8th, 10th, and 12th graders has actually risen.

At the same time, we see an increase in the number of older drug users who are showing up in emergency rooms.

We've got to do a better job at drug prevention -- sending clear, consistent anti-drug messages ...

listening to our young people ...

helping them form positive goals ...

and giving them the support they need to achieve them.

And then there's AIDS.

The Centers for Disease Control and Prevention has revealed that in 1993 AIDS overtook accidents as the number one killer of men, aged 25 to 44 in the United States.

And just this week, the World Health Organization reported that HIV cases are rising fastest among women -- and especially young girls and adolescents.

While we are still searching for a cure -- we know how to prevent the spread of HIV. And we must not be timid in sharing what we know.

The knowledge we have about preventing AIDS has the power to save millions of lives: the key is to commit ourselves not only to talking the talk -- but walking the walk -- of prevention.

Which brings me to the issue that the President asked me to place at the top of my agenda -- teen pregnancy.

And I want to commend the President in the strongest terms for his role in turning the national spotlight on this unacceptable problem.

All of the afflictions that I've just mentioned:

Violence, drug use, AIDS...

All of them are linked to the unacceptably high teen pregnancy rate in this country.

Early sex and early pregnancy so often are linked -- either as a cause or a consequence -- of violence, drug use, AIDS, poverty, and so many other negative outcomes.

Every day 8,400 teenagers become sexually active.

And every day, 2,781 teenagers get pregnant: This translates into 116 pregnancies per hour.

This is bad for the teens and even worse for their children.

We know that children born to teenagers are more likely to have serious health problems, and are more likely to be poor.

We know that about 80 percent of children born to teenage parents who dropped out of high school now live in poverty.

If we want to prevent teen pregnancy, we must offer young people more than slogans and dependency.

We must offer them something that's worth more than gold -- We must offer them a quality education, a full array of health services, and enhanced self-esteem and life-options.

Too many children today believe their only hope is having babies.

That's a dead-end dream and we've got to replace it with a dream of hope and unlimited achievement.

That's the philosophy that embodies the "I Have a Future" program we started at Meharry Medical College back in 1987.

Our approach is to expand adolescent health care programs beyond the schools, and bring them to the community, where they can become a part of the fabric of everyday life.

Our program is anchored in Nashville's public housing projects. With respect to sexuality, the emphasis first and foremost is always placed on abstinence.

The program involves entire families and the total social matrix of the surrounding community.

Everybody from parents, grandparents to politicians, volunteers, and from the clergy to business leaders has a role to play.

There are three parts to the program:

First, we equip adolescents with the basic information they need about health, human sexuality, and drug and alcohol use so they understand the benefits of abstinence and the consequences of early sexual activity and other risky behaviors.

Second, we provide a comprehensive array of adolescent health services, with a focus on abstinence. In some cases, that means access to birth control -- with a very strong emphasis on parental and community involvement.

And third, and most important, we help young people enhance their life-options through activities that improve their job skills, self-reliance, values and self-esteem.

For example, the youth entrepreneurial component of our program helps teenagers learn more about themselves and about the world of work by empowering them to start businesses in their communities.

This kind of skills-development and character-building is not only important for girls and young women -- but, as research is showing us, it is also critically important for boys and young men.

We have to take the time to understand all the unique aspects of young peoples' lives:

Building up their self-esteem, telling them we believe in them, but not simply treating them as collections of problems.

That is what we have done in "I Have a Future" -- and it works.

We know of only one of the program's participants from 1988 to 1991 who became pregnant -- compared to 59 teenage pregnancies in the two other demographically similar Nashville housing projects where "I Have a Future" is not offered.

And just last year, 16 of the 24 program participants who graduated from high school went on to college. Eight of them were male and 8 were female.

It has not been easy -- and results don't happen overnight.

In fact, it's a difficult process, and requires great dedication by many people -- but it is working.

This shows you what one community can do when it makes teenage well-being a real priority -- and I believe this kind of success is possible in every community.

But let me be clear:

As Surgeon General, I will work to empower local communities to develop comprehensive programs that fit their individual needs.

What works in Nashville may not work completely in Chicago or Charlotte.

It will be up to local communities to decide what is best for them.

The Administration and I are congruent in our emphasis on abstinence ...

... Because I believe that abstinence and aspiration are inextricably linked.

My opponents say that this nomination is about abortion. I have dedicated my medical career to taking all appropriate medical steps to meet the health needs of my patients, and that includes performing legal abortions.

I believe in the right of a woman to choose. And I also support the President's belief that abortions should be safe, legal and rare.

But my life's work has been dedicated to making sure that young people don't have to face the choice of having abortions.

To do this, we have to put life's possibilities within reach of all our young people.

One of the reasons I have hope is because there are so many positive trends out there:

Like the steady decline in smoking over the past 20 years, the steep decline in the numbers of people drinking and driving, and the steady increase in the use of seat belts.

Americans are demonstrating that, with quality leadership, we can make headway on major public health problems if we put our minds to it.

Since the President asked me to take on the job of Surgeon General, I have been in the fight of my life.

I am standing strong -- and I appreciate the strong support of the President. And I appreciate your support.

One thing I know -- my fight is no tougher than the one I'm asking all of you to join:

That's the fight to improve the health of all Americans and to prevent teen pregnancy.

I am eager to get to work, because there is so much work to be done.

I won't hesitate to call on each and every one of you for help.

These are all our children. And they need all of our help. Thank you.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

February 2, 1995

REMARKS BY THE PRESIDENT
AND DR. HENRY FOSTER, NOMINEE FOR U.S. SURGEON GENERAL

The Oval Office

2:10 P.M. EST

THE PRESIDENT: Thank you very much, Madam Secretary, and let me say it's a pleasure to have Mrs. Foster and Senator Frist, Congressman Clement here.

The Surgeon General of the United States has enormous responsibilities. As the public face of our public health service, he or she really is the people's doctor, the person responsible for promoting good health practices and alerting the nation when health threats exist.

To fill this post, I wanted someone who is both a top-flight medical professional and a strong leader and effective communicator. Dr. Henry Foster is such a person. And I am pleased today to announce my intention to nominate him as the Surgeon General of the United States.

He is widely respected in the world of medicine and science. After serving his country for two years as an Air Force medical officer, he became Chief of Obstetrics and Gynecology at Andrew Memorial Hospital at Tuskegee University.

For the past 21 years, he has worked at Meharry Medical College in Nashville, Tennessee. As the Dean of the School of Medicine and its acting president, he helped Meharry to lead the way to meeting the health needs of the poor and the underserved. At the moment, he is a visiting senior scholar at the Association of Academic Health Centers here in Washington.

In the communities he's served, Dr. Foster has won hearts and minds for his innovation and his dedication to saving the lives of young people and vulnerable people. He's received numerous honors for his work in obstetrics and dealing with sickle cell anemia and, very notably, in the prevention of teen pregnancy.

He has shown us how one person can make a difference. Eight years ago he developed and directed the "I Have a Future" program at Meharry to help stop teen pregnancy. It has been an unqualified success. Working with young people that others might think beyond help, he built up their self-esteem. He taught them job skills. He encouraged them to stay in school. Most important, he told them to be responsible for themselves. Thanks to Dr. Foster, these young people have a chance to live a good, full life.

I want Dr. Foster to use what he's learned to help America attack the epidemic of teen pregnancies and unmarried pregnancies. We know government can only do so much. So large a part of Dr. Foster's job obviously will be to use his enormous skills of persuasion to reach out to people in the private sector -- in the religious, education, entertainment, sports and other communities in this country.

MORE

birthweight, illicit drug use and the myriad of other issues which we will grapple with in the coming years.

Lastly, I wish to say again, thanks to my wife, St. Clair, my daughter, Myrna and my son Wendell, who have supported me so stoutly in all of my professional and personal endeavors.

Thank you very much. (Applause.)

THE PRESIDENT: You just hit the high point. Now you have to answer questions. (Laughter.)

Q Dr. Foster, do you think that at the -- your programs about teen pregnancy in Nashville can be applied on a national scale?

DR. FOSTER: I certainly do, and there have been efforts already to replicate the program; there is no doubt about it. It can be --

Q I hear a lot about personal commitment, but I don't hear anything about official commitment.

Mr. President, does your plan to combat teen pregnancy carry any new money with it? How do you intend to do that, or is it going to be primarily by the private sector?

THE PRESIDENT: We have a whole plan we've been working on for months, and Dr. Foster and I are going to get together and go over the outlines that we had worked on before he agreed to come on, and we will finalize that. I expect we'll be announcing it sometime in the very near future, and we'll talk about then how we intend to do it.

Q Will it take more federal money?

THE PRESIDENT: Well, I think the main thing we have to do is to galvanize the resources that are there now, spend the money that's there now better, and get -- I have been led to believe by many people all across this country that there will be an enormous amount of support for this effort in the private sector if they have confidence that it's a serious, disciplined, organized effort that is likely to work.

I might let Dr. Foster say more about that.

DR. FOSTER: No, the only thing I would add that didn't come out -- we are going to also utilize greatly the volunteer efforts. There is an emerging middle and upper black class that's doing everything now to give back. This has only developed among African Americans since World War II. And I'm surely certain that the same sort of emergence is occurring with Hispanics and other ethnic groups in this country.

Q Mr. President, does he have same license to be as outspoken and blunt as Dr. Elders did, or some areas -- did you caution him that there are some areas that he shouldn't be talking about?

DR. FOSTER: No comment. (Laughter.)

THE PRESIDENT: I can't do better than that.
(Laughter.)

Q Mr. President, some conservatives have already said that they plan to oppose your nomination because of Dr. Foster's support for distribution of contraceptive devices in public schools

Thank you very much.

Q How are the baseball talks going? Have you gotten feedback?

THE PRESIDENT: We just -- we're in it. That's all I can say. Not up, not down -- we're in it.

THE PRESS: Thank you.

END

2:24 P.M. EST



National Headquarters
500 E. Border Street, Suite 300
Arlington, Texas 76010
(817) 261-6003 / FAX (817) 277-3491
TDD (817) 277-0553

The Arc of the United States, a national organization on mental retardation, acknowledges that when Dr. Henry Foster, the nominee for Surgeon General of the United States, performed sterilization procedures on women with severe mental retardation, he was adhering to medical practices that were, unfortunately, accepted at that time.

Since then, people with mental retardation have had their rights as citizens clearly established. As citizens, they are also now recognized as people who often are able to express their own wishes and desires. Further, like all other people, their ability to make decisions is enhanced by their opportunity to live in neighborhoods and communities, to receive an education and to be employed.

Prior to the 80s many states had statutes legitimizing the sterilization of people with mental retardation. Much has changed since then, particularly rights protections requiring informed consent and improved medical practices which render procedures like hysterectomies for sterilization and hygienic purposes extremely rare. Applicable law today rigorously mandates the use of guidelines to assure that strict due process safeguards are used. Adherence to such procedures insures that the presence of mental retardation, regardless of severity, must not in itself be used to justify involuntary sterilization.

In view of the fact that sterilization of people with severe mental retardation was an accepted practice at the time Dr. Foster was engaged in such procedures, The Arc believes it has little bearing on his nomination.



National Headquarters
500 E. Border Street, Suite 300
Arlington, Texas 76010
(817) 261-6003 / FAX (817) 277-3491
TDD (817) 277-0553

The Arc of the United States, a national organization on mental retardation, acknowledges that when Dr. Henry Foster, the nominee for Surgeon General of the United States, performed sterilization procedures on women with severe mental retardation, he was adhering to medical practices that were, unfortunately, accepted at that time.

Since then, people with mental retardation have had their rights as citizens clearly established. As citizens, they are also now recognized as people who often are able to express their own wishes and desires. Further, like all other people, their ability to make decisions is enhanced by their opportunity to live in neighborhoods and communities, to receive an education and to be employed.

Prior to the 80s many states had statutes legitimizing the sterilization of people with mental retardation. Much has changed since then, particularly rights protections requiring informed consent and improved medical practices which render procedures like hysterectomies for sterilization and hygienic purposes extremely rare. Applicable law today rigorously mandates the use of guidelines to assure that strict due process safeguards are used. Adherence to such procedures insures that the presence of mental retardation, regardless of severity, must not in itself be used to justify involuntary sterilization.

In view of the fact that sterilization of people with severe mental retardation was an accepted practice at the time Dr. Foster was engaged in such procedures, The Arc believes it has little bearing on his nomination.

Removal of the Normal Uterus*

HENRY W. FOSTER, JR., MD,† Tuskegee, Ala

15

Southern Medical Journal

JOURNAL OF THE SOUTHERN MEDICAL ASSOCIATION

VOL. 69

JANUARY 1976

NO. 1



Published monthly by
THE SOUTHERN MEDICAL ASSOCIATION, Birmingham, Alabama, U.S.A. 35205
Copyright © 1976 The Southern Medical Association Printed in the United States of America

Removal of the Normal Uterus*

HENRY W. FOSTER, JR., MD,† Tuskegee, Ala

ABSTRACT: The uterus is often justifiably removed when anatomically it is a normal organ. Unfortunately, such surgery often is viewed with suspicion because there is failure to communicate the justification to patients and uninformed critics. An effort is made in this manuscript to categorize procedures and thus more clearly delineate the indications for removal of the normal uterus. Reviewed is a total of 485 hysterectomies performed over a ten-year period in a medical school affiliated hospital providing training in obstetrics and gynecology for second-year residents and for third- and fourth-year medical students. Eighty-two of the 485 uteri removed (16.9%) were considered anatomically normal by the criteria set forth. The morbidity associated with these cases was minimal.

OBSTETRICIANS AND GYNECOLOGISTS must guard vigilantly against the injudicious and indiscriminate removal of the normal uterus. Failure to do so will only serve to reinforce much of the hostility and suspicion currently directed toward our discipline. However, much of the hostility and suspicion is unnecessary and exists because there is failure to communicate the concept that removal of the anatomically normal uterus can be completely justifiable. In fact, in some circumstances it is imperative that this normal organ be extirpated. Consequently, efforts must be made to inform patients and uninformed critics.

Basic textbooks of gynecology make little or no reference to removal of a normal uterus per se. Therefore, I wish to delineate more clearly those conditions under which removal of the normal uterus constitutes acceptable surgical practice. I am cognizant that this involves much that is subjective and philosophical and that there will not be unanimous agreement with the opinions presented. I hope, though, that these opinions and judgments will serve as a point of reference to place this controversial subject in better perspective and to improve communications between physicians and patients regarding this surgical procedure.

To determine what constitutes a normal uterus is not always a simple task. Nonetheless, some criteria must be set. It is estimated that the adult nulliparous and parous uteri have average weights of 60 and 90 gm respectively. It also is estimated that one out of five women past the age of 30 has either clinical or subclinical myomas.¹ For the purpose of this paper, any uterus weighing less than 150 gm, possessing no myomas greater than 4 cm in diameter, and showing no abnormal microscopic change is considered normal.

It is believed that the first hysterectomy was performed in 1843 by Charles Clay of Manchester, Eng-

land, although his patient died on the 15th postoperative day. The first completely successful hysterectomy was done by Dr. Walter Burnham of Lowell, Mass, in 1853.² However, it was well into this century before this procedure approached any acceptable mortality and morbidity figures. Thanks to the 20th Century advances in surgical techniques, blood banking and infection control, hysterectomy has become a basically safe procedure, although mortality and morbidity have by no means been reduced to zero. In a large, well respected training hospital in this country, the mortality from this procedure was 0.5%.³

Moreover, the associated nonfatal complications are not to be taken lightly. Though infrequent, the most common serious complication of hysterectomy is bleeding requiring postoperative suturing in 0.8%.⁴ Other frequently encountered complications occur in the urinary tract. A study in 1962 reported a 1% incidence of unilateral ureteral ligation associated with total hysterectomy.⁵

Fistula formation frequently complicates hysterectomy. Ureteral-vaginal fistula is rare except when the ureters are skeletonized as with radical cancer surgery. Also, rarely, rectovaginal fistulas result from injury to the sigmoid colon or rectum in the course of hysterectomy.

It has been shown that laceration of the urinary bladder occurs in 2% of hysterectomies.⁶ Fistula formation here, however, can be essentially eliminated if the injury is recognized promptly and repaired properly.

Significant morbidity is thus a real threat whenever hysterectomy is undertaken and is reason enough to demand great care in patient selection.

INDICATIONS FOR OPERATION

The justification for removal of the normal uterus is clearer in some instances than in others. Table 1 lists what I have termed *established* indications for removal of the normal organ, as well as *relative* indications for this procedure.

Although hysterectomy, usually vaginal, is employed

TABLE 1. Indications for Removal of the Anatomically Normal Uterus

<i>Established Indications</i>	<i>Relative Indications</i>
Ovarian cancer	Sterilization
Oviduct cancer	Mental retardation
Vaginal cancer	Ectopic pregnancy
Chronic pelvic inflammation	Familial history of cancer
Endometriosis	Pelvic pain
Genital prolapse	Hydatid mole
	Postirradiation of uterus
	Benign ovarian disease
	Pelvic tuberculosis
	Postpartum hemorrhage
	Dysfunction bleeding

*Read before the Section on Obstetrics and Gynecology, National Medical Association, Seventy-ninth Annual Meeting, New Orleans, La, July 29-Aug 3, 1974.

†From the Department of Obstetrics and Gynecology, John A. Andrew Memorial Hospital, Tuskegee, Ala. Dr. Foster is now with the Department of Obstetrics and Gynecology, Meharry Medical College, Nashville, Tenn.

Reprint requests to Dr. Foster, 1005 N 18th Ave, Nashville, Tenn 37208.

for sterilization it is not a universally accepted practice. Most gynecologists perform hysterectomy for sterilization only when there are other, more generalized indications for removal of the uterus. Recently, I have begun to use hysterectomy in patients with severe mental retardation. Hysterectomy can be done either for sterilization or to eliminate the menses, which is of significant hygienic benefit in these severely handicapped individuals.

Hysterectomy often is the procedure of choice in both interstitial pregnancy and ectopic pregnancy when a single remaining tube is involved and must be removed.

Whether to perform hysterectomy for dysmenorrhea or generalized intractable pelvic pain is a difficult decision because of the subjectivity of this complaint. It is recommended that a psychiatric perspective be sought when no organic cause for pain can be found.

More liberal use of hysterectomy in the presence of the normal uterus could be warranted in patients with a strong family history of genital malignancy, ie, in a sibling or parent. Such a change in philosophy may be plausible, and it is interesting to note that more women now die annually in this country from ovarian cancer than from cervical carcinoma.⁷

Fortunately, the intracavitary use of radium for the control of benign uterine bleeding has been abandoned. Studies have revealed a relatively high occurrence of carcinosarcoma in patients treated in this manner; consequently, prophylactic hysterectomy appears justified.⁸

Also, after evacuation of a molar pregnancy in a woman who has borne as many children as she desires, even in this day of effective chemotherapy, I can see no advantage in uterine conservation.

Possibly, in the patient over 35 with benign ovarian neoplastic cysts, hysterectomy should also be done. Secondary malignant degeneration may occur in any of these neoplastic tumors and they all possess a varying capacity for bilaterality.

Hysterectomy may be indicated in patients with diabetes mellitus. This consideration seems reasonable since it has been shown that the coexistence of this disease and endometrial carcinoma is frequent. It has been reported that 20% of all patients with endome-

trial carcinoma have overt diabetes and one half of these patients have abnormal glucose tolerance curves.⁹

The modern treatment of genital tuberculosis is active and prolonged therapy with streptomycin and isoniazid. However, operation becomes necessary if there is no change in the pelvic findings after four months of this regimen.

In the woman with severe dysfunctional bleeding, the number of children she has had should determine whether a hysterectomy is in order.

Again, reproductive desires dictate the course of action in severe postpartum hemorrhage. In the young patient who has further procreative desires, ligation of the internal iliac artery should be done. If necessary, both ovarian arteries in addition to both hypergastric arteries should be ligated. Pregnancy and delivery can follow these procedures and are completely uncomplicated.¹⁰

MATERIAL AND DISCUSSION

I have reviewed my experience with hysterectomy over the past ten years at the John A. Andrew Memorial Hospital in Tuskegee, Alabama (Table 2). Between May 1963 and May 1973, 485 hysterectomies were done. Of these, by the criteria set forth in this manuscript, 82 (16.9%) of the uteri removed were normal. Of these 82, 41 (50%) fell into the group defined as having established indications (Fig 1).

Pelvic inflammation by far was the most frequent

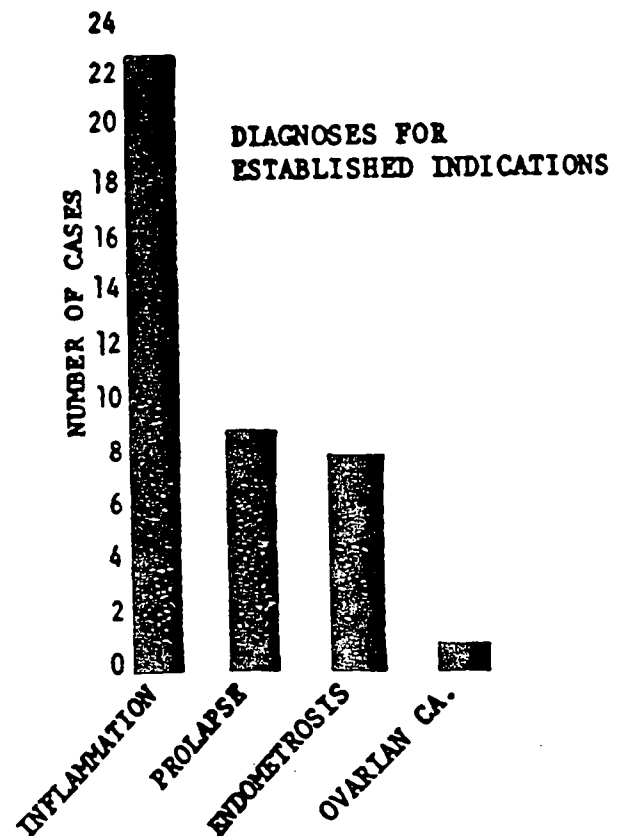


FIGURE 1. Diagnoses for established indications (n=41).

TABLE 2. Ten-Year Experience With Hysterectomy

Time Period Studied	Total No. Cases	Anatomically Normal Uteri No. Cases	% of Total
May 1963 - May 1964	64	8	12.5
May 1964 - May 1965	49	7	14.2
May 1965 - May 1966	38	7	18.4
May 1966 - May 1967	43	9	20.9
May 1967 - May 1968	30	13	26.0
May 1968 - May 1969	47	5	10.6
May 1969 - May 1970	51	6	11.7
May 1970 - May 1971	53	10	18.8
May 1971 - May 1972	38	11	28.9
May 1972 - May 1973	52	6	11.5
Totals	485	82	16.9

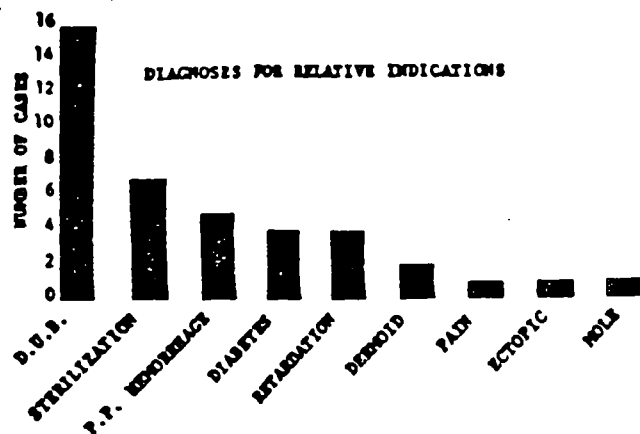


FIGURE 2. Diagnoses for relative indications (n=41).

indication for removal of the normal uterus. All nine hysterectomies for genital prolapse were by the vaginal route and were combined with anterior and posterior colporrhaphy. Of the eight cases of endometriosis (9.8%), only one patient was white. I believe the disease occurs more frequently in blacks than the literature suggests. The single case of ovarian cancer was a unilateral serous cystadenocarcinoma.

The 16 cases (19.5%) of dysfunctional uterine bleeding constituted the most frequent diagnosis in the group of relative indications (Fig 2). Admittedly, some may choose to put this diagnosis in the group of estab-

lished indications. It is interesting that only one hysterectomy (1.2%) was done exclusively for intractable pelvic pain. Certainly, many of these patients had varying degrees of pain but when more than one symptom was present, only the predominant or primary symptom was recorded as the indicated cause for operation. The single hysterectomy done for ectopic pregnancy (1.2%) was a case of intraligamentous pregnancy.

There were no fatalities among the patients having normal uteri removed. In addition, there was only minimal morbidity. Only one patient (1.2%) developed significant postoperative bleeding, which was easily controlled with several sutures placed vaginally. There was no known injury of the urinary tract, and none of the 82 patients developed any clinical thromboembolic disease.

References

1. Parson L, Sommers SC: *Gynecology*. Philadelphia, W. B. Saunders Co., 1963, p 702
2. Te Lende RW, Mattingly RF: *Operative Gynecology*. Philadelphia, J. B. Lippincott Co., 1970, p 2
3. Mengert WF: Practical obstetrics and gynecology—the open line. *Ob-Gyn News* 8:28, 1973
4. Smith RD, Pratt JH: Serious bleeding following vaginal or abdominal hysterectomy. *Obstet Gynecol* 26:592-595, 1965
5. Freda VC, Tacchi D: Ureteral injury discovered after pelvic surgery. *Obstet Gynecol* 33:406-409, 1967
6. Graber ER, O'Rourke JJ, McElrath T: Iatrogenic bladder damage during hysterectomy. *Obstet Gynecol* 23:267-273, 1964
7. Drucker BH, Hodgkinson CP: Ovarian carcinoma—perspective for the 70's. *Am J Obstet Gynecol* 109:825-837, 1971
8. Schellley LC: Malignancy subsequent to irradiation of the uterus for benign conditions. *Am J Obstet Gynecol* 44:925-951, 1942
9. Vander JB: The association of diabetes mellitus and carcinoma of the endometrium. *Am J Obstet Gynecol* 77:243-245, 1959
10. Mengert WF, Burchell RC, Blumstein RW, et al: Pregnancy after bilateral ligation of the internal iliac and ovarian arteries. *Obstet Gynecol* 34:664-666, 1969

Clinical Management: Sickle Cell State and Pregnancy

By
Henry W. Foster, Jr., M.D., F.A.C.O.G.
Professor and Chairman
Department of Obstetrics
and Gynecology
— Meharry Medical College
Nashville, Tennessee



Henry W. Foster, Jr., M.D.

Several years ago, I was appalled upon reading an article recommending primary sterilization for sickle cell disease patients. This report originated at one of this country's larger teaching hospitals caring for a sizable black population.¹ In the article, a true maternal mortality rate of 10 per cent was reported, a rate which simply is unacceptable in the contemporary practice of obstetrics. A current maternal mortality rate of that magnitude is an indictment of the care being provided by the institution.

With exemplary care, I do not believe the maternal mortality rate for the homozygous (Hb-S-S) and the doubly

heterozygous (Hb-S-C) and (Hb-S-Thal) sickle cell states should ever exceed 3 per cent in this country.

While I recognize that this is a formidable ideal, the decision to risk pregnancy is an option which can justifiably be afforded by the expectant mother. I do not believe there is an experience more significant or rewarding than reproducing one's own kind.

Indeed, one of our greatest concerns of management when sickle cell disease is a complication relates to the type of advice and counsel provided to black patients regarding potential risks they incur when pregnant. Too often, the counsel provided is highly inaccurate, misleading, and, on occasion, dangerous. In order to obtain the very best maternal and child health outcomes for these patients, there must be provided accurate screening, informed counseling, and exemplary clinical management. Without this sequential three-pronged approach, maternal mortality figures can be expected to approach those reported by Forte, et al.¹

In the George W. Hubbard Hospital of Meharry Medical College, we have a management program which we believe provides all required entities. All screening is by hemoglobin electrophoresis conducted by the Meharry Sickle Cell Center, and all direct patient care and counseling is provided by the obstetrical and social service staff of the Department of Obstetrics and Gynecology.

Our management approach recognizes no reduction of fertility or increase in either fetal wastage or maternal mortality in those pregnant patients with sickle cell trait (Hb-S-A). Urinary tract infections have been reported to be two and a half times more frequent in these patients when compared with the general population. However, improved research design is needed to be conclusive on this point. Nonetheless, there is a theoretical basis to explain this occurrence. Increased osmolality enhances sickling of affected erythrocytes, and in the kidney circulation the osmolality increases fourfold as blood flows from the cortex to the medulla. Ultimately this can lead to infection, nephron destruction, and hyposthenuria — the inability to concentrate urine — which has been reported as occurring more frequently in sickle cell trait patients.

Accordingly, urine cultures and sensitivity studies are performed on all sickle cell trait patients. Those found to have positive cultures are treated with appropriate antibiotics. Those whose cultures are negative are nonetheless treated with mild urinary antiseptic agents, e.g. methenamine madelate-phenazopyridine (Azo-mandelamine).

In a single recent study, an increased incidence of premature rupture of the membranes in patients with sickle cell trait was reported.² However, we have not observed this phenomenon on our service. Aside from a possible increased incidence of urinary tract infection, it is our feeling that the single most-significant factor in managing pregnant patients with sickle cell trait is the necessity of providing adequate genetic counseling.

Providing care for patients with homozygous or doubly heterozygous forms of sickle cell disease requires the very finest in obstetrical expertise if maximal outcome is to be achieved. For convenience, we divide pregnancy management into four phases: (1) initial visit (usually in the late first trimester or early second trimester), (2) third trimester, (3) labor and delivery, and (4) postpartum. Procedures at the patient's initial visit include repeat hemoglobin electrophoresis, serum electrophoresis, blood grouping and typing, hemogram including reticulocyte count, urine culture and sensitivity, blood chemistries, liver function tests, and consultations with hematology, cardiology, pulmonary, social and dietary services.

After taking a complete history and conducting a physical examination, the patient is evaluated and advised of the availability of pregnancy termination. If after intense counseling she chooses this option, the procedure is effected with suction curettage up to the thirteenth week of gestation (from last menstrual period). In the second trimester (after the fifteenth week) we utilize prostaglandin F² alpha preceded 12 hours with insertion of a laminaria tent. The majority of our patients, however, do not choose the option of abortion. Our fundamental management, therefore, focuses on blood replacement or exchange, prevention of infection and intense social service support.

Until recently, most centers — including our own — have utilized replacement transfusions to maintain hemoglobin levels in the 7-9 grams percent range. However, recently there have been several very encouraging reports wherein partial exchange transfusions are utilized prophylactically, rather than therapeutically with crises. A protocol for this procedure is described in a recent article by Morrison and Fish.³

The objective of this therapeutic approach is to replace initially a proportion of Hb-S with Hb-A to achieve a hematocrit of at least 35 per cent and a Hb-A content of 40 per cent. This procedure usually requires 750 to 1000 milliliters of buffy-coat poor washed red

Continued on page 52.

Sickle Cell

Continued from page 20.

cells. These values should be rechecked at six-week intervals, with a crisis, or with the onset of labor. The partial exchange transfusion should be repeated when the hematocrit becomes less than 25 per cent and or the Hb-A content is less than 20 percent. Exchange transfusions have been utilized to varying degrees for many years, but usually were employed only with crises.^{4,5} Complications from the procedure until recently have been excessive. Preliminary reports now tend to indicate that complications are declining significantly with new and refined blood transfusion techniques.

Due to the short life span of the sickle cell erythrocyte population, folate metabolism is increased, thereby requiring folic acid supplementation. On the other hand, iron therapy is usually unnecessary and may even contribute to iron storage disease. All patients are provided prenatal vitamins.

At least 25 percent of sickle cell disease patients develop urinary tract infections, and twice this number have positive urine cultures. During initial hospitalization, kidney function is evaluated and urinary tract antibiotics in some form are provided to all patients. Cardio-pulmonary evaluation is done, and the patient is discharged to be seen at least twice monthly. Every effort is made at all times to preclude any form of infection but especially respiratory infection but especially respiratory infections.

Complications in the second trimester are not particularly common, provided the patient has been seen earlier and is followed appropriately. However, as pregnancy nears term, the likelihood of morbidity increases sharply. Toxemia of pregnancy is reported as high as 22 percent and endometritis and thrombophlebitis have been reported at 19 percent.

Although there is little in the literature to support the concept of early delivery in patients with sickle cell disease, we have nonetheless employed elective early delivery in these patients. The rationale for this third trimester management is based on the following. First, the frequency and severity of complications increase as pregnancy nears term especially in patients with hemoglobin C disease. Secondly, elective delivery obviously will not be timed to coincide with the occurrence of a crisis, which may be the situation if the spontaneous onset of labor is awaited. Further, we believe that fetal lung maturation is accelerated in fetuses of these patients.

The basic elements of third trimester management include hospitalization at 36-37 weeks, partial exchange transfusions as indicated, fetal assessment for well being and maturity and induction of labor. Amniocentesis is an acceptable procedure in these patients. Placental and fetal localization is achieved with B-scan ultrasonography. Amniotic fluid is examined routinely for its lecithin/sphingomyelin ratio, creatinine, fat cells and bilirubin. Additionally, urinary or serum estriol levels are measured and oxytocin challenge tests are conducted. Cesarean section when employed is based solely on obstetrical indications.

Labor in these patients, either spontaneous or induced, should be managed much the same as labor in cardiac patients. Over sedation should be avoided and oxygen is administered. Epidural analgesia and anesthesia is used for labor and delivery and obviates the need for narcotics. However, fluid replacement is a critical factor and is easily mismanaged. Sickle cell disease patients frequently fall into negative fluid balance. Most have impairment of renal concentrating capacity and thus excrete excessive quantities of urine. And, as with most patients in labor, they lose their appetites and therefore have impaired food and fluid intake. Hence, intravenous fluid replacement should include not only ample amounts of water/dextrose solutions but also adequate electrolyte replacement. These patients tend to have metabolic acidosis, and correction can be achieved with lactate or bicarbonate solutions monitored with daily serum electrolytes.

Catheterization of the urinary bladder is to be avoided if at all possible, and broad spectrum antibiotics should be administered for at least 96 hours into the postpartum period. Digitalization of the patient should be done, if necessary, to prevent congestive heart failure, which occurs more frequently in the postpartum period.

Management of a crisis in the pregnant sickle cell disease patient differs little from the procedures employed in the nonpregnant state. Most crises which occur are of the vaso-occlusive type producing intense pain. Aplastic (aregenerative) crises are only about one-fifth as common as vaso-occlusive crises, and acute sequestration crises are mostly confined to childhood. The basic components of crisis management include (1) analgesics; (2) partial exchange transfusions; (3) intravenous fluid and electrolyte replacement; (4) oxygen administration; and (5) elimination of infection.

Providing adequate family planning to the sickle cell patient can present an extreme challenge to the obstetrician-

gynecologist. We offer sterilization to any patient who has achieved a successful delivery. If this procedure is accepted by the patient, it is done after the six week postpartum period utilizing spinal anesthesia for surgical tubal ligation and resection. We do not recommend laparoscopic sterilizations in these patients since we require general anesthesia for laparoscopic procedures.

The intrauterine device is not used in sickle cell disease patients on our service. Endometritis frequently results from its use. This can progress to a more generalized pelvic infection including pelvic peritonitis, ultimately precipitating a crisis.

What then is our stance regarding oral steroid contraceptives? Theoretically, these drugs are contraindicated because they increase blood coagulability thereby lowering the threshold for crises. The estrogen component of this estrogen-progestin medication is the major offender. Accordingly, if used, a low dose or even better, an estrogen-free oral contraceptive is the wisest choice.

It must not be forgotten that some of the less effective but safer methods of contraception, e.g. diaphragms and condoms, are acceptable provided patient motivation is adequate. However, with such contraceptive management, therapeutic abortion clearly must be an option made available to the patient who fails at contraception.

Lastly, we make no distinction in our contraceptive management of the patient with sickle cell trait.

Over the past 20 years a vast amount of knowledge has been accumulated and a greater understanding of the entire sickle cell disease process now exists. With our improving knowledge of genetic counseling, pregnancy management, and contraceptive technique, we can expect even better maternal outcomes with this disease.

REFERENCES

1. Forte, A.T.; Morrison, J.C.; Berarez, L.; Diggs, L.W.; Fish, S.A.: Counseling the patient with sickle cell disease about reproduction: Pregnancy outcome does not justify the maternal risk! *American Journal of Obstetrics and Gynecology*. 111:324, 1971.
2. Rimer, B.A.: Sickle cell trait and pregnancy: A review of a community hospital experience. *American Journal of Obstetrics and Gynecology* 123:3, 1975.
3. Morrison, J.C.; Fish, S.A.: Sickle cell hemoglobinopathies and pregnancy: Current concepts. *OB/GYN Digest*. 15:23, 1976.
4. Ricks, P.: Exchange transfusion in sickle cell anemia and pregnancy. *Obstetrics and Gynecology*. 25:117, 1965.
5. Ricks, P.: Further experience with exchange transfusion in sickle cell anemia and pregnancy. *American Journal of Obstetrics and Gynecology*. 100:1087, 1968.

COPYRIGHTED

A RURAL HOSPITAL AND FAMILY PLANNING

Henry W. Foster, M.D.
Chief, Obstetrics and Gynecology
John A. Andrew Memorial Hospital
Tuskegee, Alabama

INTRODUCTION BY ROBERT A. HATCHER, M.D.

Dr. Henry W. Foster hails from Pine Bluff, Arkansas. He was graduated from Morehouse College and the University of Arkansas Medical School. He had one year of surgery training prior to his OB-GYN residency at Meharry Medical College in Nashville. He is currently Chief of the Obstetrics and Gynecology Service at the John A. Andrew Memorial Hospital, Tuskegee, Alabama, and is Director of their Maternal and Infant Care Project.

I was very much impressed with you, Hank, and your service when I visited you way back in the spring of 1966 with Dr. John Thompson.

I look forward very much now to your reflections on the delivery of family planning services in your hospital.

A RURAL HOSPITAL AND FAMILY PLANNING

Even under the most ideal circumstances the problems of effectively implementing family planning are, indeed, difficult and often impossible. However, the frustration and futility so frequently encountered in family planning are only compounded when the setting is rural.

Macon County, Alabama, located in the southeastern part of the State typifies rurality and many of its problems. The County has a land area of 616 square miles. There are 24,841 inhabitants of which just over 11,000 reside in Tuskegee, the County Seat and the location of Tuskegee Institute, and Tuskegee's Veterans Administration Hospital. There is a smaller community of about 1,000 people with the remainder being scattered on mostly small farms throughout the County.

Family Planning services are also provided to Bullock County and partially to Russell County. Bullock County has a land area of 616 square miles and Russell County, a land area of 639 square miles. The population of Bullock County is 11,820, and the population of Russell County is 45,994. These three Counties very well parallel each other in their rural makeup and it is in this setting, primarily, that our family planning services are conducted.

In addition to speaking on the problems of family planning in a rural setting, I have also been asked to give a black physician's views on family planning. I shall speak to the latter aspect first.

In recent years, there has been an outcry by various groups that the intent of family planning is black genocide and that the ultimate effect will be black genocide. I must admit that these apprehensions are quite understandable and often not without foundation. In June of 1970, the First National Congress on Optimal Population and

Environment convened in Chicago, Illinois. Invited participants included about 45 blacks representing such moderate black institutions as the Urban League, Tuskegee Institute, and Howard University. Shortly after the Congress convened this group of individuals formed a black caucus on an ad hoc basis. After considering the major problems being discussed and the solutions proposed, the caucus observed that the Congress in its planning had been derelict in obtaining significant black input to reflect black interest, and that the purpose of the conference was to use those delegates invited to legitimize a pre-conceived plan of vicious extermination. If to many of you these views seem irrational, it is to some degree understandable. The majority of this Country's health providers have never even in the vaguest way planned a program of genocide for black people. What has occurred, however, is that many well intentioned family planning programs have been set up for large segments of our black population without adequate consideration of many other factors. Without consideration of such factors which I shall mention shortly, the end results of far-reaching family planning programs can have very disastrous consequences for black people. Nonetheless, I support family planning but this support is of necessity, conditional. I consider it axiomatic that the following conditions first be met: 1) that all programs be completely voluntary and that no coercive family planning programs be allowed to become a part of a National or local legislative policy; 2) that comprehensive health care be a viable component of any family planning program, and 3) that all family planning programs for blacks include blacks at all meaningful policy making and administrative levels. It is absolutely

essential that these three prior conditions be met and to do otherwise is, in my judgement, unthinkable. All too often, the family planning services being provided are not voluntary. Consumers, many times, are cajoled by not only physicians but almost any member of the family planning team. Patients are belittled and berated, often openly, if they refuse services or even show reluctance. Far more frightening though is when coercive sterilization laws are enacted. Social welfare legislation in this form removes the right of a woman on welfare to have children.

Other areas of health care must be given as high a priority as family planning. I am cognizant of the positive aspects of family planning; but, just how far these positive aspects go in the face of deficient comprehensive health care I cannot answer. In fact, I pose the following questions: 1) Is it wise to attempt to approach a National zero population growth in a group where infant deaths are twice the National average? 2) Might not a higher birth rate in such a group, at some point, be a protective mechanism where the life expectancy is significantly less than the National average. Too often family planning is given a disproportionately higher priority than are other essential areas of health care. In my own State, for example, I am suspect when I see extensive family planning services being provided in a locale where if the same patients become pregnant they cannot even receive obstetrical care there but must travel more than one hundred miles across the State passing numerous adequate hospitals.

Most family planning programs are predicated on the erroneous

assumption of a common national life style. Because of the difference in life styles, it is essential to include blacks at meaningful policy making and administrative levels when providing family planning services for black people. To those that are deprived socially and economically the procreative processes often become the only fulfilling life experiences available. To curtail or remove this avenue of expression is often tantamount to taking away the only need for existence itself. Therefore, it is fundamental for the providers of family planning services to have this insight. Every human being has the need to feel creative. It is a drive not easily relinquished. The challenge is to continue to make available other avenues of expression for this creative need.

The problems of family planning are magnified when the setting is rural. Sociologists, when describing barriers to health care delivery, often use the terms "attitudinal" and "organizational." Generally attitudinal barriers prevent the individual from becoming motivated to seek the available service. Whereas organizational barriers keep the motivated individual from utilizing the services that are desired.

Rurality is characterized by a relatively unsophisticated folk culture and at times is actually primitive. There is a distinctive form of social organization which is seen in the institutions of family, religion, government, and education and reflects the deprivation caused by cultural, geographic and economic isolation. Because of this isolation and resulting unsophistication the rural psychology is strongly oriented to fatalism which in great part explains their strong resistance to any alteration in reproduction and the reproductive process. This factor creates a tremendous barrier to family planning motivation in this segment of our population. Any highly successful family planning program will remain unattainable so long as such strong attitudinal barriers exist.

01.12.95 01:17 PM with INFO SPECIALISTS POS

Organizational barriers confronting the motivated rural patient seeking family planning services are numerous and weighty. However, unlike attitudinal barriers, these are less intangible and, consequently, more readily identifiable. Poverty constitutes an awesome barrier and is inseparable from all other barriers. Poverty is in no way unique to the rural setting but beyond all doubt, the depth of this deprivation here is equaled in no other quarter of our society. For Macon County, the median family income is only \$2,428.00 per year and 56.9% of the families earn less than \$3,000.00 annually.

Problems of transportation and communication are quite unique in the rural setting. The inaccessibility of health care centers characterizes rurality because of the distances involved and the absence of public transportation. Such problems constitute real barriers to health care delivery. Because of the existing poverty, the number of privately owned vehicles is quite low. Many patients hire private transportation but the cost is often prohibitive. Transportation is also hampered by an underdeveloped road and highway system in many rural areas.

The rural problems of mass communication parallel those of transportation. The literacy rate among rural dwellers is lower, consequently, the effectiveness of newspapers is much reduced. Although the distribution of radios in rural areas is relatively high, there are few television sets and telephone service is deficient. Also, in spite of the advances in rural electrification, there are still many homes that have never known this service. It, thus, becomes apparent that the mere dissemination of information is a very difficult task.

Adequate health manpower, distribution and utilization create still other unique barriers to rural health care delivery. The overall shortage of medical and paramedical personnel is well known but here again this

problem is amplified in a rural setting. In Alabama, there are 2,627 active physicians. The State Population is 3,444,165 with a ratio of one physician per 1,311 people. The National ratio is one physician per 821 people. When the distribution of Alabama's physicians is examined it is noted that the five most populous counties have 1,718 physicians and 1,432,658 people or a ratio of one physician per 833 people which compares quite favorably with the National average; however, the five counties with the least population and, of course, the most rural have but 17 physicians and 56,768 people or a ratio of just one physician per 3,339 people. The problem then of maldistribution becomes quite evident and obviously impedes greatly health care delivery among the unurbanized.

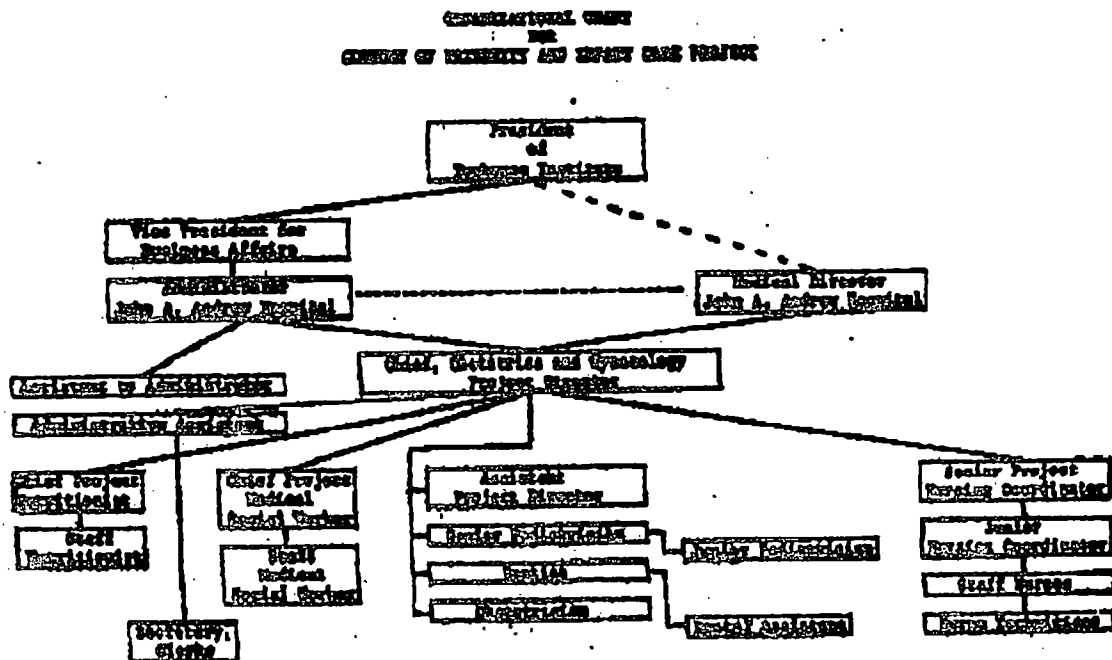
Although the setting is rural, John A. Andrew Memorial Hospital is an ultramodern 180 bed facility located on the campus of Tuskegee Institute. It is in the outpatient section of the hospital that our maternity and infant care team is based.

There are 35 positions funded in our maternity and infant care project--the vehicle through which family planning services are rendered to the three county area. (Figure 1) The organizational structure of this team is shown in figure 2. Family planning clinics are conducted independently and in conjunction with antenatal clinics. The clinic schedule is shown in figure 3 and averages 15 clinic sessions per month. All services provided outside of Macon County are performed in county health facilities with state employed public health nurses.

Prior to the completion of our new outpatient building our health care team conducted four satellite clinics away from Tuskegee but in Macon County. Although the physical condition of these satellite clinics is woefully inadequate, the State continues to use these places to

PERSONNEL FOR THE PROJECT #956

- | | |
|---------------------------------|------------------------------|
| 1. Project Director | 19. Dental Assistant |
| 2. Asst. Project Director | 20. Obstetrician |
| 3. Chief Pediatrician | 21. Staff Nurse |
| 4. Junior Pediatrician | 22. " " |
| 5. Chief Medical Social Worker | 23. " " |
| 6. Staff Social Worker | 24. " " |
| 7. Chief Project Nutritionist | 25. " " |
| 8. Staff Project Nutritionist | 26. " " |
| 9. Project Administrative Asst. | 27. " " |
| 10. Senior Nursing Coordinator | 28. " " |
| 11. Junior Nursing Coordinator | 29. Licensed Practical Nurse |
| 12. Junior Nursing Coordinator | 30. Licensed Practical Nurse |
| 13. Clerk, Medical Records | 31. Nursing Assistant |
| 14. Clerk, Business Office | 32. Nursing Assistant |
| 15. Clerk | 33. Nursing Assistant |
| 16. Clerk | 34. Nursing Assistant |
| 17. Secretary | 35. Nursing Assistant |
| 18. Dentist | |



conduct services. The physical setting is modern at our hospital as is the new health department building in Bullock County. The physical facility at the Hartaboro clinic in Russell County is inadequate and must be improved.

Since abandoning the satellite clinics in Macon County a bus route has been established where patients are picked up and returned to the same geographic location of the previous satellite clinics. This service is funded in our grant as patient transportation. Our maternity and infant care personnel physically go into Bullock and Russell Counties.

During the previous calendar year, there were 2,400 family planning visits of which 960 were new patients. In addition, through our in-patient services we performed 193 tubal sterilization procedures. These figures, though low and in need of improving, are respectable when the low population density being dealt with is realized. Moreover, this allows us to place higher emphasis on quality and comprehensive care.

In conclusion, it can be seen that most of the problems in the delivery of family planning services to minorities and to the rural have a common genesis--that of economic, social and cultural isolation. As a black physician, I well see the value of family planning, but also as a black physician I know I must be perceptive enough to distinguish family planning from population control. The latter is easily disguised as the former. They are not the same; there is a difference. Some of these differences have been pointed out here today. At Tuskegee, we have mounted an attack on health problems in general of which family planning is a part.

-241-

FAMILY PLANNING CLINIC SCHEDULE
8 A. M. to 12 Noon

1st & 4th Friday..... Family Planning Clinic (exclusively)
Tuskegee (Macon County)

Every Monday & Tuesday.... Family Planning in conjunction with
Prenatal Clinic
Tuskegee (Macon County)

1st & 3rd Thursday..... Family Planning in conjunction with
Prenatal Clinic
Hartsville (Russell County)

2nd & 4th Thursday..... Family Planning in conjunction with
Prenatal Clinic
Union Springs (Bullock County)

Contraceptives in Sickle Cell Disease

HENRY W. FOSTER, JR., MD,⁺ Nashville, Tenn

ABSTRACT: Choosing the proper method of contraception for patients with sickle cell disease is an empiric exercise. In this manuscript, the commonly used contraceptive methods are examined for their risk-benefit ratio. However, because of its extensive use and effectiveness, steroid contraception is examined in greatest depth. Physiologic and pathologic changes induced by oral steroid contraceptives are evaluated, and their potential effects on patients with sickle cell disease are considered. Physiologic alterations evaluated are carbohydrate metabolism, blood lipid levels, hepatic function, thyroid function, and pigment changes. Pathologic changes reviewed are hypertension, thromboembolic phenomena, myocardial infarction, amenorrhea, and emotional changes. The choice of sterilization procedures is also considered for these patients.

THE PROVISION of contraceptives for female patients with homozygous and doubly heterozygous sickle hemoglobinopathies is an unsettled and challenging issue. Computer search of the world's literature over a most recent 40-month period yielded but a single article devoted exclusively to contraception and sickle cell hemoglobinopathies.¹ For the sickle cell disease patient who has successfully negotiated a pregnancy, the contraceptive question is often sealed by the patient's choice of a sterilization procedure. However, for those who do not choose this method and for nulligravida patients, the difficult decision remains. Lack of definitive data on this subject has made the provision of contraception to patients with sickle cell disease an empiric exercise.

At the onset, it should be emphasized that contraceptive management of patients with sickle cell *trait* is no different from that of the normal population. Hence, comments contained here are applicable only to patients with sickle cell disease.

Contraceptive methods can be grouped into the following six broad categories: (1) steroid contraception, (2) intrauterine devices, (3) barrier methods, (4) timing methods, (5) sterilization, and (6) abortion. Although some discussion will be afforded each of these methods, the greater portion of time will be devoted to the more effective method of steroid contraception since it is clearly this method that presents the most controversy.

The most widely used form of hormonal contraception is the combination pill containing synthetic progestins and estrogens. Pills containing progestin only are used on a very limited basis, as is the long-acting intramuscular medroxyprogesterone acetate (Depo-

Provera). Although not a steroid, diethylstilbestrol (DES) under special circumstances has a contraceptive applicability. There is no consensus as to whether sickle cell disease constitutes an absolute or relative contraindication to the use of steroid contraception, but there are few, if any, who do not suspect some increased risk factor. Given this lack of definitive data upon which to make this judgment, it appears logical to review the known physiologic and pathologic changes induced by steroid hormones. Having done this, coupled with an understanding of the natural history of sickle cell disease, one should be in a better position to make a reasonable judgment as to the contraceptive role, if any, of steroid hormone in patients with sickle cell disease.

Physiologic alterations in carbohydrate metabolism, blood lipids, hepatic function, thyroid function, and pigmentation may result from oral steroid contraception. The combination oral contraceptives have been shown to increase fasting blood glucose in 10% to 25% of normal patients. Theoretically, this could place sickle cell patients at some increased risk of infection. Progestins alone have no known adverse effect on carbohydrate metabolism.

Plasma levels of triglycerides and phospholipids have been found to rise in patients using combination oral contraceptives. The mechanism by which this occurs is unknown, but may relate to increased hepatic production. Ordinarily, there are no known long-term effects, but patients with established hypertriglyceridemia become worse and thus more prone to acute vascular accidents.

Some patients using oral contraceptives have an increase in SGOT and alkaline phosphatase levels. Moreover, marked liver impairment is one of the absolute contraindications to steroid usage. This has particular relevance for patients with sickle cell disease.

⁺From the Department of Obstetrics and Gynecology, Meharry Medical College, 1005 N 18th Ave, Nashville, Tenn 37208.
Reprint requests to Dr. Foster at the above address.

given their chronic hemolysis which predisposes them to cholelithiasis.

Although there is some alteration in results of thyroid function tests similar to those seen in normal pregnancy (ie. increased thyroid-binding globulin leading to increased PBI, increased T_4 , and decreased T_3 uptake), the free thyroxin index and thyroid function remain normal.

The physiologic increase in pigmentation seen in approximately one third of pill users is of no clinical consequence.

Pathologic alterations also attributable to combination steroid contraceptives are (1) hypertension, (2) thromboembolic phenomena, (3) myocardial infarction, (4) amenorrhea, and (5) emotional lability and depression. It is this category of alterations that understandably causes us greatest concern in all patients when prescribing steroid contraceptives.

Over the past decade there have been many reports showing a relationship between the estrogen component of the pill and hypertension. The incidence is usually in the neighborhood of 15% to 20%, with about 5% of the patients reaching dangerously high blood pressure levels. Both the systolic and diastolic pressures increase, and both normotensive and previously hypertensive patients can be affected. The mechanism of action is not known but probably is by way of the direct action of estrogen on the juxtaglomerular cells. The hypertension is thought to be of the renin-dependent type, since there is an increase in renin and renin substrate. Although not an absolute contraindication, this feature of the estrogen-containing pill most certainly would be of significant concern in a patient with sickle cell disease.

Thromboembolism constitutes a most serious untoward effect of the birth control pill. Current data show a sevenfold increase in the risk of death from thromboembolic disease for oral contraceptive users over nonpregnant nonusers, the increase in the risk of death being 15 per million and 2 per million respectively. A previous history of deep vein thrombosis is a contraindication to use of the pill, and it is believed by

some that sickle cell disease also constitutes a contraindication to the use of estrogen.⁸ The increased coagulability seen in patients with sickle cell disease appears to add a modifying risk factor that may make the pill unacceptable. Although the effect of sickle cell disease as a modifying risk factor in pill users has not been established, it is interesting to note the effect of other similar modifying factors as presented by the Center for Disease Control's Epidemiologic Studies Branch, Family Planning Evaluation Division, Bureau of Epidemiology.

Examined in the Table is the risk of complications in oral contraceptive users with a specified risk factor(s) compared to normal contraceptive users without a risk factor(s). Severe hypertension in patients taking oral contraceptives increases the risk of thrombotic stroke by just over 13-fold and the risk of hemorrhagic stroke just over 25-fold. The modifying risk factor of cigarette smoking (not controlled for age) also increases the risk, but to a lesser extent than severe hypertension. It could therefore be assumed that sickle cell disease, too, can be viewed as an increased risk factor with respect to use of oral steroid contraceptives.

An increased incidence of myocardial infarction seems to occur only in women who have passed 40 years of age and then only in those who have other coexisting risk factors, eg. hypertension, obesity, and smoking. This consideration, therefore, should be of no great significance for the patient with sickle cell disease or any other patient, since most practitioners do not prescribe oral contraceptives in this age group.

The pathologic alterations of amenorrhea and emotional lability after use of the pill have no known special significance for patients with sickle cell disease.

Because of the thromboembolic phenomenon caused by combination oral contraceptives and because of the increased incidence of thromboembolic disorders in sickle cell disease, the use of oral steroid contraceptives is considered relatively contraindicated in patients with sickle cell disease.

It is also believed that the use of DES as an after-the-fact contraceptive agent is contraindicated in patients with sickle cell disease for the same reasons stated in regard to the combination pill. Moreover, the equivalent dosage of estrogen required here is some 50 to 100 times that of the estrogen contained in the low-dose combination birth control pill.

Progestin-only contraceptives such as the mini pill and long-acting intramuscular progesterone have been suggested for patients with sickle cell disease. Theoretically, this estrogen-free medication should pose a lesser threat, but there are no good data that clearly exempt progestins as a causative or contributory factor to the thromboembolic phenomenon. Ad-

TABLE. Major Harmful Effects of Birth Control Pills (BCP): Modification of Those Effects by Other Factors*

Complication	Modifying Factor	Risk of Complication in BCP Users vs Non-BCP Users † Risk Factors
Thrombotic stroke	None	3.0:1
	Severe HCVD*	13.6:1
	Smoker, ≥1 pack/day	6.1:1
Hemorrhagic stroke	None	1.5:1
	Severe HCVD	25.7:1
	Smoker, ≥1 pack/day	7.6:1

*From Ory HW: The health effects of fertility control. Presented at the National Academy of Sciences Symposium on Contraceptive Technology, May 16, 1978.

†Hypertensive cardiovascular disease.

ditionally, it has been suggested that the intermediate metabolism of progestins may involve conversion to estrogen.

The use of medroxyprogesterone acetate (Depo-Provera) for contraception in patients with sickle cell disease has been suggested, but the same questions previously raised remain unanswered. Moreover, because this agent is not approved in this country for contraceptive use, there are significant medicolegal implications. It would appear, therefore, that the use of DES and all steroid contraceptives, including the progestins, should probably be avoided.

What then is the role, if any, for the second most effective form of reversible contraception—the intrauterine device? Here, too, there seems to be no consensus among practitioners. Again, to make a judgment requires an evaluation of the known complications associated with IUDs. The two complications that bear the greatest relevance to patients with sickle cell disease are infection and excessive hemorrhage. Irrespective of the technic used for insertion, bacteria are introduced into the uterine cavity, and although the bacterial count usually decreases after a few weeks, it has been suggested that endometritis persists. Moreover, most serious complications from IUDs, including death (0.3 to 1.0 per 100,000 IUD users per year) and sepsis,⁸ are related to infection. Because of the known adverse effect of infection on the patient with sickle cell disease, this feature, it seems, renders the IUD inappropriate for them.

IUDs tend also to increase the incidence of both menorrhagia and metrorrhagia; hence the adverse effects of excessive bleeding on sickle cell disease present another reason why the IUD probably is best not used in these patients.

The complications of expulsion, perforation, and ectopic pregnancy take on greater significance when the patient has sickle cell disease. This is particularly true for perforation and ectopic pregnancy, where infection and the need for surgery become likely.

Since contraceptive effectiveness and safety bear inverse relationships to each other, we are now left to consider the less effective but safer barrier methods of contraception. Condoms, diaphragms, foams, and jellies are acceptable forms of contraception in well motivated patients. With adequate patient education, the barrier contraception recommended for patients with sickle cell disease is a spermicidal jelly containing nonoxynol-9, used preferably with a diaphragm. In addition, the patient is taught how to calculate her probable day of ovulation; at this time her sex partner is advised to use a condom in addition to her jelly and/or diaphragm. The condom should be added during the three days before, the three days after, and on the calculated date of likely ovulation. Although this contraceptive approach may appear complex, with

adequate education patient compliance can be often achieved in these usually highly motivated patients. Nevertheless, therapeutic abortion is an option that must be made available to patients who fail with this contraceptive approach.⁴

In the strictest sense, sterilization should not be considered a form of contraception because of its irreversibility. It is, however, a form of fertility control very often chosen by these patients and hence warrants comment. With the current popularity of laparoscopic sterilization, it should be emphasized that this procedure compromises to some degree lung aeration, because of the relatively high fixed position of the diaphragm. Further, in 90% of the laparoscopic procedures conducted in this country, carbon dioxide is used to establish the pneumoperitoneum, which results in hypercarbia.⁵ The elevated PCO_2 and lowered pH have been shown to be the result of carbon dioxide absorption from the peritoneal surface and not necessarily due to improper ventilation during anesthesia.⁶ It is well known that hypercarbia, decreased pH, and decreased oxygenation all predispose patients with sickle cell disease to crises. For this reason, it is believed that laparoscopic sterilization should not be used in these patients. As an alternative, the interval "mini lap" sterilization procedure, using local anesthesia, is recommended.

The use of abortion solely as a form of contraception, though acceptable in some parts of Europe, has not become prevalent in the United States. Clearly this would not be ideal in sickle cell disease. This method would necessitate an operative procedure through 16 weeks' gestation, and thereafter termination procedures would require the use of prostaglandins or hypertonic saline infusions, with their inherent risk of complications and possible subsequent abdominal surgery.

Of the six broad methods of fertility control discussed—steroids, IUDs, barrier methods, timing methods, sterilization, and abortion—effectiveness versus safety is the basis upon which choices must be made. Because steroids, IUDs, and abortions probably carry too great a risk and because sterilization is inappropriate if reversibility is a consideration, barrier methods combined with timing probably offer the best balance between safety and effectiveness.

References

1. Adaderoh BK, Dade OA: Contraception and haemoglobinopathies in Ibadan, Nigeria: an evaluation on the effect on anaemia. *Trop Geogr Med* 29:77-81, 1977
2. Romney SL, Gray MJ, Little AB, et al: *Gynecology and Obstetrics, The Health Care of Women*. New York, McGraw-Hill, 1975, p 562
3. Hatcher RA, Stewart GK, Stewart F, et al: *Contraceptive Technology*, 1978-1979. New York, Irvington Publishers, 1978, p 76
4. Foster HW: Clinical management: sickle cell state and pregnancy. *Urban Health* 6:20, 57, 1977
5. Wortman JS: A review of complications of laparoscopic sterilization. *Advances in Female Sterilization Techniques*. Scarra JJ, et al (eds). Hagerstown, Md, Harper and Row, 1976, pp 37-47
6. Alexander GD, Brown EM: Physiologic alterations during pelvic laparoscopy. *Am J Obstet Gynecol* 105:1078-1081, 1966

FAMILY PLANNING AND THE BLACK COMMUNITY

Henry W. Foster, Jr., M.D.
Department of Obstetrics and Gynecology
Meharry Medical College
School of Medicine
Nashville, Tennessee

The concept that every woman in the childbearing age should have the right to maintain control over her own fertility is, I believe, an accepted principle in 1975. However, for patients to be able to recognize and exercise this right, there is the need to conduct a massive educational effort: (a) to have health personnel include family planning as a part of the comprehensive health services they provide; (b) to educate the public (the patient) to appreciate good health and how to maintain it. The assumption is that the patient (the woman in this instance), once emancipated from her own ignorance is likely to take over control of her own fertility.

In structuring family planning services, there are some basic principles that must be adopted and adhered to very strictly. Briefly, they are:

1. Voluntary family planning is a significant health measure. Family planning information must be provided in such a way whereby autonomy is maintained.
2. Family planning services must be delivered humanely and in physical surroundings that are adequate.
3. Male participation in family planning must be sought.
4. Family planning settings can provide many noncontraceptive services for patients.
5. Population concerns are inappropriate for family planning programs.
6. Abortions are safer when performed in early pregnancy.

Any family planning services which do not embrace all of these principles are deficient and potentially harmful especially for the ghetto population.

The potential benefits to be derived by the provision of adequately structured and properly delivered family planning services are well established. In addition to the achievement of optimal family size by those obtaining voluntary family planning services, there will follow the other expected benefit of family planning—the improvement of health. Thus family planning means better health and I am in accord with the broadened definition of health as adopted by the World Health Organization (WHO):

"A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

There obviously is a need to lower infant mortality and decrease maternal mortality and morbidity. This need can be addressed by better spac-

ing of wasted pregnancies and the avoidance of unwanted pregnancies. Particular attention must be paid to women in high risk groups which so often characterize the inner city childbearing population.

Some maternal mortality findings relating to high risk groups are of particular note, e.g., maternal mortality rates for patients under 20 years of age are about one-third higher than those for patients aged 20-24. Toxemia and abortion related deaths are 2 times higher for women under 20. Other studies from the population council have shown that the newborn of a teenage mother has a 30% increased risk of dying prior to its first birthday. Premature births for women under 20 is 34% higher than for mothers in the 20-24 age range. Furthermore, a very large proportion of women seeking abortion are not using birth control measures. Again, this is magnified in the teenager. For older mothers, those over 40, the infant mortality rises sharply as it does in mothers after the fifth pregnancy.

Based on these facts, how then could there be anything other than overwhelming reception of family planning services by everyone? How could there be resistance to these services? The answers to these questions, of course, are multiphase, complex and like so many complex issues, are deeply embodied in the sociocultural fabric of the environment.

When describing barriers to the health services, of which we speak, sociologists often use the terms, "attitudinal" and "organizational." Generally, attitudinal barriers prevent the individual in need from becoming motivated to seek the available service, whereas organizational barriers prevent the motivated individual from utilizing the services that are desired. Most often a combination of both barriers is at work when needs go unmet and obviously the problems of family planning are increased when the setting is an urban inner city.

Ghetto life is in general characterized by a relatively unsophisticated culture which has resulted in great part from the economic and political isolation that has characterized this group. Because of isolation, there is a strong orientation towards fatalism which helps explain resistance to any alteration in reproduction and the reproductive process. This factor creates a significant barrier to family planning motivation in this segment of our population. Consequently, successful family planning programs will remain difficult to achieve as long as attitudinal barriers exist.

Organizational barriers confronting the motivated ghetto patient seeking family planning services are often overwhelming. However, unlike attitudinal barriers, organizational barriers are more tangible and thus more readily identifiable. In this regard, poverty constitutes an awesome barrier and is inseparable from all others. Additional organizational barriers are maldistribution of health personnel, problems of transportation, communications and deficient physical facilities. A complex interface of the attitudinal barrier involves collectively the ghetto patient and his or her physician both of whom often are Black.

In recent years there has been an outcry by various groups that the

intent of family planning is Black genocide and that the ultimate effect will be Black genocide. These apprehensions are quite understandable and on occasion are well founded. In June of 1970, the first National Congress on Optimal Population and Environment convened in Chicago, Illinois. Invited participants included about 45 Blacks representing such Black institutions as the Urban League, Tuskegee Institute, and Howard University. Shortly after the Congress convened, this group of individuals formed a Black Caucus on an ad hoc basis. After considering the major problems being discussed and the solutions proposed, the ad hoc group observed that the Congress in its overall planning had been derelict by failing to obtain significant Black input to reflect Black interests and concluded that the purpose of the Conference was to use those delegates invited as pawns to legitimize a preconceived plan of vicious extermination. If these views seem irrational, it is to some degree understandable. There is no doubt that there are those in this country who indeed would be delighted if Blacks became extinct.

However, it is my firm conviction that the majority of this country's health providers have never in a conscious manner planned a program of genocide for Black people and indeed are motivated by a sincere desire to be beneficial. What has occurred, however, is that many well-intentioned family planners and family planning programs have been set up for large segments of the Black population, without due consideration of many significant factors to which they can relate. Without consideration of such factors, the end results of far-reaching family planning programs can have very disastrous consequences for Black people. Nonetheless, because of the inherent health benefits that can be derived from properly structured family planning programs they have my support as a Black physician, but this support is of necessity conditional. Accordingly, I consider it axiomatic that the following three basic conditions be met prior to my lending support to any family planning program:

1. All family planning programs must be completely voluntary and that no coercive family planning programs be allowed to become part of a national or local legislative policy.
2. Comprehensive health care must be a viable component of any family planning program including the capability of infertility diagnosis and therapy.
3. All family planning programs for Blacks must include effective Blacks at every substantive policy making and administrative level.

It is absolutely essential that these three prior conditions be met and to do otherwise is totally unacceptable.

All too often, family planning services being provided are not voluntary. Consumers many times are unfairly cajoled by not only physicians but almost any member of the family planning team. Patients are belittled and berated often openly if they refuse services or even show reluctance. Far more frightening than this, however, is the legalization of coercive ster-

lization practices. Social welfare legislation in this form removes the right of a woman receiving welfare benefits to have children.

Additionally, other areas of health care must be given as high a priority as family planning. I believe that the case for the positive aspects of family planning has been established, but just how far these positive aspects go, in the face of deficient comprehensive health care, cannot be answered. In fact, I pose the following question: Is it wise to attempt to approach a national zero population growth in a group where the infant deaths are twice that of the national average? Might not a higher birth rate in such a group at some time serve as a necessary protective mechanism in that group where the life expectancy is significantly less than that of the national average? All too often, family planning is given a disproportionately higher priority than are other essential areas of health care. I am suspect when I see extensive family planning services being provided in a locale where, if the same patients become pregnant or require other health services, none are available.

Most family planning programs are predicated and structured on the erroneous assumption of a common national life style. Because of the differences in life style characteristics of this country's heterogenic make-up, it becomes mandatory to include Blacks at meaningful policy making and administrative levels when structuring and providing family planning services for Black people. To those who are deprived socially and economically the procreative processes often become the only fulfilling life experience available. To curtail or remove this avenue of expression is often tantamount to taking away the only need for existence itself. Therefore, and in conclusion, it is fundamental for the providers of family planning services to have the recommended insight. Every human being has a need to feel creative—it is a drive not easily relinquished. The challenge to us as professionals and as a nation therefore is to continue to make available to everyone many avenues of expression for this creative need.

Meigs' Syndrome Complicated by Pregnancy

HENRY W. FOSTER, M.D., F.A.C.O.G.

Reprinted from

JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION

September, 1971. Vol. 63, No. 9, pp. 372-373

Copyright, 1971 by The National Medical Association

Meigs' Syndrome Complicated by Pregnancy

HENRY W. FOSTER, M.D., F.A.C.O.G.,

*John A. Andrew Memorial Hospital,
Tuskegee Institute, Alabama*

IN 1937, Meigs and Cass reported seven cases of fibroma of the ovary accompanied by ascites and hydrothorax. Though rare, the importance of this condition should be fully appreciated. Solid tumors are far less common than benign cystic tumors and for that reason, should be generally considered as potentially malignant. Meigs' Syndrome, therefore, points out the fact that a solid ovarian neoplasm can be responsible for ascites and hydrothorax and yet be completely benign.

Since 1937, there have been many subsequent reports of this condition. However, its association with pregnancy is, indeed, an infrequent occurrence. During the 35-month period from January 1966, through November 1968, computer analysis of the world literature revealed but a single naturally occurring case of Meigs' syndrome and pregnancy co-existing. The author here adds another case to the literature.

CASE REPORT

O.B., a 35-year-old unmarried black woman, gravida 9, para 5, abortus 3, was admitted on Feb. 15, 1968, having been referred from her county health department with a diagnosis of "polyhydramnios." She was well until three weeks prior to admission, at which time her abdomen began to enlarge rapidly. Her last normal menstrual period had begun sometime in Nov. of 1967. A week after the onset of her abdominal enlargement she developed increasing chest pain, shortness of breath and nausea and vomiting which followed most meals. She denied other gastrointestinal, renal, cardiovascular, respiratory or pelvic complaints.

Her past medical history and systems review were essentially noncontributory and her previous pregnancies were uncomplicated aside from three spontaneous abortions occurring in the first trimester. However, her social history revealed that she was the head of a two-room household composed of one adult, that being herself, and four children ranging in age from three to 16 years. She was unemployed and received no welfare assistance.

On admission, her blood pressure was 110/80, temperature 98.4, pulse 78, respiration 20, weight 205 pounds, and height 64 inches. Physical findings were limited to the lungs, abdomen and pelvis. The lower one-fourth of the left lung field presented percussion dullness both anteriorly and posteriorly. There were no rales or rhales

and the right side was completely clear to percussion and auscultation. The abdomen was markedly distended to the xiphoid process approximately the girth of a term pregnancy, but different in contour. No fetal heart tones were audible and there was a positive fluid wave. On the left side, mostly in the lower quadrant, there was a firm ballotable mass whose size could not then be ascertained. Pelvic examination revealed a normal introitus. The vaginal mucosa was blue and the cervix was soft, blue and enlarged with the external os closed. The corpus and adnexa could not be accurately assessed, nor could the origin of the ballotable mass be established.

Hospital Course: Hematologic studies revealed the following: Hemoglobin 10.4 gms.%, hematocrit 36 vol.%, white cell count 8,450, blood type O-Rh positive, and sickle cell preparation negative. Other test results were: pregnancy test positive; creatinine .95; potassium 3.1 mEq/L; chloride 96 mEq/L; carbon dioxide 21 mEq/L; total serum protein 5.9 gms.%, albumin 1.9 gms.%, globulin 4.0 gms.%, amylase 26 units, urinalysis—pH 5.0, specific gravity 1.023, albumin trace, glucose negative, acetone negative, and numerous white blood cells. Papanicolaou stain of the ascitic fluid showed Class I (absence of neoplastic or atypical cells), many mesothelial cells, histiocytes and lymphocytes. Anterior-posterior and lateral x-ray views of the pelvis revealed no fetal skeleton and only "a general haziness over the abdomen due, very likely, to a mass or ascites or both. Chest x-ray on Feb. 23, 1968, showed the left costophrenic angle to be filled with a density and some fluid extending up the lateral chest wall from the surface of the density (Fig. 1). The electrocardiogram was reported as normal.

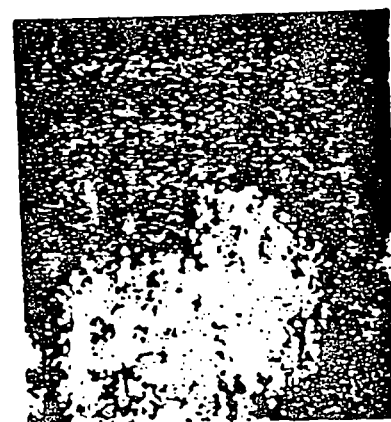


Fig. 1. Chest x-ray showing a density in the left costophrenic angle and fluid extending up the lateral chest wall.

On Feb. 26, 1968, abdominal paracentesis was performed and 2,500 ml. of a straw-colored fluid were removed. Repeat pelvic examination at this time revealed more clearly a pelvic mass thought to be at least 12 cm. in diameter. Medical and urological consultations were obtained and on March 8, 1968, an exploratory laparotomy was performed. Upon entering the peritoneal cavity, a serosanguinous fluid was encountered which measured 1,500 ml. Arising from the left infundibulopelvic ligament completely replacing the ovary was a solid ovoid mass measuring 24.0 x 20.0 x 12.0 cm. and weighing 2,200 gms. Its surface presented rough excrescences and extensive loose omental adhesions. The uterus appeared gravid though no corpus luteum could be identified. A total abdominal hysterectomy, right salpingo-oophorectomy, left salpingectomy, left ovarian cystectomy and partial omentectomy were performed (Fig. 2).

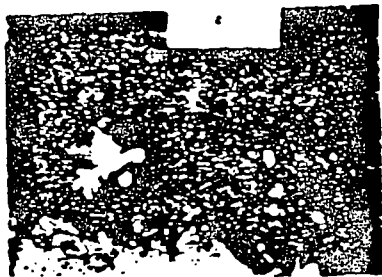


Fig. 2. Specimens removed at surgery. The ovarian mass is noted on the left and the uterus with the fetus are on the right.

Her postoperative course was one of progressive improvement and she was discharged completely asymptomatic on her 9th postoperative day. Estrogen replacement was instituted prior to discharge. She has since been seen on several occasions and eight months later remained asymptomatic.



Fig. 3. Photomicrograph of the ovarian fibroma. Note the uniformity of the cells. H. & E. X350.

Pathological diagnoses were: Fibroma of ovary (Fig. 3), intrauterine gestation approximately 18 weeks, chronic cervicitis, normal uterus and oviducts and hemor-
rhagic omentum.

COMMENTS

The size of the ovarian fibroma would indicate that it antedated the pregnancy even though the ascites and hydrothorax did not become manifest until the pregnancy was well established; consequently, it is felt that this is a case of Meigs' syndrome complicated by pregnancy rather than the reverse.

Approximately 40 per cent of all ovarian fibromas over 6.0 cm. in diameter will be accompanied by excessive peritoneal fluid. The added element of fluid in the pleural cavity appears with only 3 per cent of cases and the association with pregnancy is indeed a most infrequent occurrence.

Unfortunately, at our hospital, immediate frozen sections are not available. At laparotomy, the solid tumor, the extensive excrescences and omental adhesions pointed to a strong possibility of malignancy; consequently, total extirpation of the pelvic organs was carried out. The dismal social history made this decision just a bit less difficult.

In addition to the solid ovarian tumor, ascites and hydrothorax, this case fulfills a fourth criterion set forth by Meigs in 1954, that of being cured after removal of the tumor.

LITERATURE CITED

1. MEIGS, J. V. Pelvic Tumors other than Fibromas of the Ovary with Ascites and Hydrothorax. *Obstet. Gynecol.* 3:471, 1954.
2. MEIGS, J. V., and S. H. ARMSTRONG, and H. H. HAMILTON. A Further Contribution to the Syndrome of Fibroma of the Ovary with Fluid in Abdomen and Chest. *Meigs' Syndrome Amer. J. Obstet. Gyn.* 16:19, 1913.
3. MEIGS, J. V. and J. W. CASE. Fibroma of the Ovary with Ascites and Hydrothorax, with a Report of 7 Cases. *Amer. J. Obstet. Gyn.* 33:249, 1937.
4. NOVAK, E. R. and J. D. WOODRUFF. Other Tumors of the Ovary. *Gynecologic and Obstetric Pathology*, 2nd Ed., W. B. Saunders Company, Philadelphia, 1967, p. 365.
5. PARSON, L. and S. C. SOMMER. Solid Benign Tumors of the Ovary. *Gynecology*, 1st Ed., W. B. Saunders Company, Philadelphia, 1962, p. 774.
6. TAYLOR, E. S. Benign Tumors of the Ovary. *Essentials of Gynecology*, 3rd Ed., Lea and Febiger, Philadelphia, 1965, p. 256.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re: Dr. Foster (2 pages)	n.d.	P5

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Lyn Hogan
OA/Box Number: 11027

FOLDER TITLE:

Henry Foster Nomination 1995

2010-1083-S

rc448

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1** National Security Classified Information [(a)(1) of the PRA]
- P2** Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3** Release would violate a Federal statute [(a)(3) of the PRA]
- P4** Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5** Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6** Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1)** National security classified information [(b)(1) of the FOIA]
- b(2)** Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3)** Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4)** Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6)** Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7)** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8)** Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9)** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Date: 02/11/95 Time: 14:49

White House Defends Foster's Sterilizing Retarded Women in 1960s

WASHINGTON (AP) The White House played down the significance Saturday of revelations that President Clinton's nominee for surgeon general had performed hysterectomies to sterilize some severely retarded women in the 1960s and 1970s.

White House press secretary Mike McCurry said the information was available to administration officials before Clinton's selection of Dr. Henry Foster. He said Foster, in scholarly writings, had "eloquently" explained his conduct in the context of medical thinking for that time.

"We wanted to know more about the circumstances of this, what the medical practices were at the time," McCurry said. "We looked into the matter."

Administration officials said Foster, along with the mainstream medical community, no longer considers sterilization of retarded women by hysterectomy to be appropriate.

"Should senators wish to question him about these matters, he will be in a good position to address them," McCurry said.

The administration volunteered the names of prominent doctors who said it had been accepted medical practice decades ago to perform hysterectomies on severely retarded women for hygienic reasons and for sterilization.

"There have been many changes over that 25 to 30 years in the care of all patients," said Dr. George Wilbanks, chairman of the Rush Memorial Medical College in Chicago and president-elect of the American College of Obstetrics and Gynecology. "He's changed with the times."

The administration is promising to push ahead with Foster's nomination despite growing opposition from anti-abortion forces upset that he performed 39 abortions during his decades as a obstetrician-gynecologist. Some senators also have raised concern about Foster's credibility because of shifting accounts of how many abortions he performed.

Foster, speaking out on his own behalf in recent days, has defended a woman's right to an abortion and stressed that most of the abortions he performed were in cases of rape, incest or medical necessity. He added that his life's work has been to discourage young people from becoming parents too soon.

The drumbeat of criticism continued Saturday nonetheless. Commentator Patrick Buchanan told the Conservative Political Action Committee the nomination should be rejected because "any man who performs abortions is not morally qualified to stand in the bully pulpit of surgeon general of the United States."

Foster's nomination has not been formally submitted to the Senate because an FBI background check has not been completed. Attorney General Janet Reno declined to comment Saturday on the status of the FBI review but called Foster's credentials "very impressive."

On the issue of hysterectomy, Foster wrote in the Southern Medical Journal in January 1976 that doctors must guard against "injudicious and indiscriminate removal of the normal uterus," but that there are times when it is "acceptable surgical practice."

Foster went on to say that most gynecologists "perform hysterectomy for sterilization only when there are other, more generalized indications for removal of the uterus. Recently, I have

begun to use hysterectomy in patients with severe mental retardation."

He said hysterectomies could be performed on retarded women "for sterilization or to eliminate the menses, which is of significant hygienic benefit in these severely handicapped individuals."

A chart accompanying the article showed that between 1963 and 1973, Foster performed 485 hysterectomies at the John A. Andrew Memorial Hospital in Tuskegee, Ala., 82 of them on women who had a normal uterus.

Six of those were listed as having been done for sterilization, but it was unclear if the women were mentally retarded. The others had complicating conditions that led to the hysterectomies.

APNP-02-11-95 1451EST

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. note	re: Dr. Foster (4 pages)	n.d.	P5

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Lyn Hogan
OA/Box Number: 11027

FOLDER TITLE:

Henry Foster Nomination 1995

2010-1083-S

rc448

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]